Section II

Definitions & Descriptions

PROVIDER MANUAL
FOR
COMMUNITY MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES
PROVIDERS
UNDER CONTRACT WITH
THE DIVISION OF MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES AND
ADDICTIVE DISEASES

JULY 2005

CONSUMER ELIGIBILITY

I. MENTAL HEALTH AND ADDICTIVE DISEASE TREATMENT AND SUPPORT

(NOTE: In FY06 changes were made to consumer eligibility requirements for receipt of mental health and addictive disease services. "Most in Need" criteria were replaced by the "Core Customer" criteria.

CONSUMER ELIGIBILITY- ADULT CORE CUSTOMER
STATE-FUNDED ADULT MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

Overview of Core Customer Definitional Elements for Adult Mental Health and Addictive Diseases State Funded Services:

1. The individual must be 18 years of age or older (Persons who are emancipated minors under Georgia Law may be considered adults for the purpose of this definition as long as they are to receive adult services rather than children's services.)
2. The individual must have a diagnosable mental illness and/or substance related disorder on Axis I, in accordance with the latest edition of the DSM.
3. The individual's level of functioning must be significantly affected by the mental illness and/or substance related disorder.

A. SERVICE ACCESS

Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted.

1. Screening and Referral- Screening is available for adult mental health and addictive disease services to **all individuals** who are 18 years of age or older.

For the purposes of this definition, **screening** refers to a brief assessment of an individual's need for services to determine whether there are sufficient indications of a mental illness and/or substance related disorder to warrant further evaluation. A screening may be initiated at any location in the service delivery system:

a. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, then an appropriate **referral** to other services or agencies is provided.

b. If the individual does appear to have a mental illness and/or substance related disorder, then core customer status is reviewed as a part of a comprehensive evaluation. The individual is referred to the designated agency or agencies for the service area for a comprehensive evaluation.

2. **Comprehensive Evaluation-** A **comprehensive evaluation** including diagnostic, functional and financial components is completed in accordance with accepted clinical practice and Division standards. Determination of core customer status for state funded services is completed as a part of the comprehensive evaluation. Information gathered during the comprehensive evaluation is used to identify the treatment, rehabilitation and recovery supports needed by the individual.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are three variables for consideration to determine whether an individual qualifies as a "core customer" for adult mental health and addictive disease services.

1. **Age-** An individual must be over the age of 18 years old. Individuals under age 18 may be served in adult services if they are emancipated minors under Georgia Law, and if adult services are otherwise clinically/developmentally indicated.

2. **Diagnostic Evaluation-** The state MHDDAD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports a psychiatric disorder and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnosis.

3. **Functional/Risk Assessment-** Information gathered to evaluate an individual's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes the individual's resource utilization, role performance, social and behavioral skills, cognitive skills, communication skills, independent living skills, personal strengths and adaptive skills, needs and risks as related to a psychiatric disorder, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

C. BRIEF INTERVENTION AND STABILIZATION- ADULT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Brief Intervention and Stabilization services is six visits or less (excluding the initial screening assessment).

Brief Intervention indicates interventions of short duration taking place after a problem (e.g. a psychiatric disturbance/disorder and/or substance related disorder) is already suspected or identified, but that occur early enough to potentially avoid escalation of the problem into a crisis situation or into a chronic/severely disabling disorder. **Stabilization** also indicates interventions taking place after a problem has been identified (e.g. a psychiatric disturbance/disorder and/or substance related disorder), but which has either

already developed into a crisis situation or has become disabling enough to warrant at least short-term (though perhaps intensive) stabilization interventions.

In order for an individual to qualify for **Adult MENTAL HEALTH AND ADDICTIVE DISEASES BRIEF INTERVENTION AND STABILIZATION services,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The person must have an Axis I diagnosis or diagnostic impression of a mental illness and/or a substance related disorder. An individual may either start out in the On-going service category or be transitioned to this category at any point during or following Brief Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances/stressors etc.

2. **Functional-** At least **one** of the following must be present:

   a. The person's level of functioning must be significantly affected by the presenting mental health or addictive disease issue; **and/or**
   b. The person displays behaviors that are disruptive to the community and the family/support system; **and/or**
   c. The person displays behaviors that demonstrate a substantial risk of harm to self or others.

D. ONGOING SUPPORT AND RECOVERY- ADULT MENTAL HEALTH

Ongoing Support and Recovery: Indicates interventions taking place after a psychiatric disorder of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the individual in order to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services is anticipated to be longer than six visits (though how much longer varies by utilization guidelines, service needs, and bio-psycho-social factors affecting functioning). An individual may either start out in the Ongoing services category or be transitioned to this category at any point during or following Brief Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors etc.

In order for an individual to qualify for **Adult MENTAL HEALTH ONGOING SUPPORT AND RECOVERY services,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual must have an Axis I diagnosis (**note:** not just a diagnostic impression) of a severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder that requires ongoing and long-term support, treatment and recovery services. The prognosis indicates a long-term, severe disability. Without supports, hospitalization or other institutionalization (e.g. incarceration) is probable.

2. **Functional-** The individual's ability to function has been **significantly affected by the mental disorder** to the degree that there is impairment in activities of daily living with an inability to function independently in the community. This difficulty with activities of daily living and difficulty in functioning independently must be demonstrated **EITHER** by ***both "a" and "b"*** below, **OR** ***by "c" alone, or in place of "a" or "b":***

   a. The individual's score on the Daily Living Activities (DLA) Scale indicates moderate to extremely severe impairment in at least FOUR areas of daily living activities (i.e. **FOUR DLA scale items**):

   --AND—

   b. At least **FOUR** of the following areas of the individual's life are significantly adversely affected by the mental disorder:

   - Problems maintaining employment.
   - Inability to manage and organize daily activities.
   - Inability to maintain a stable housing situation.
   - Relationships with natural support system are problematic and involve discord or isolation.
   - Withdrawal, alienation and/or deterioration in interpersonal interactions.
   - Involvement with the legal system.
   - Previous or current treatment has not achieved remission of symptoms or the individual is unable to effectively manage the symptoms.
   - History of frequent hospitalization or a long-term hospital stay related to a mental disorder.
   - Significant risk of harm to self or others with or without a conscious plan.
   - Binge or excessive use of substances that have resulted in potentially harmful behavior.
   - Evidence or history of self-neglect that compromises the ability to care for self.
   - Behavior that is disruptive to the community.
   - Physical health is affected by the mental illness and the individual's ability to function.
   - Involvement with multiple social service agencies.

   --OR--

   c. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and does not currently meet the functional criteria. Without the supports/services provided, the individual would likely be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the functional criteria.

E. ONGOING SUPPORT AND RECOVERY- ADULT ADDICTIVE DISEASES

Ongoing Support and Recovery: Indicates interventions taking place after a substance related disorder has been identified and has become disabling enough to warrant ongoing service provision to help support the individual in order to improve his or her level of functioning and recovery. The length of Ongoing Support and Recovery services is anticipated to be longer than six visits (though how much longer varies by utilization guidelines, service needs, and bio-psycho-social factors affecting functioning). An individual may either start out in the Ongoing services category or be transitioned to this category at any point during or following Brief Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors.

In order for a person to qualify for **Adult ADDICTIVE DISEASE ONGOING SUPPORT AND RECOVERY services,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The person has an Axis I diagnosis (**note:** not just a diagnostic impression) of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin.

2. **Functional-**The individual's level of functioning has been significantly affected by the substance related disorder to the degree that there is a marked decrease in health and in ability to function. This decrease in health or in functioning must be demonstrated by "a" **or** "b" below:

   a. At least **ONE** of the following areas of the individual's life is significantly adversely affected by the substance related disorder:

   - Failure to fulfill major role obligations at work, school or home.
   - Problems maintaining employment.
   - Inability to maintain a stable housing situation.
   - Organization of daily activities around substance use.
   - Continued substance use despite having social or interpersonal problems caused or exacerbated by the effects of substances.
   - Behavior that is disruptive to the community.
   - Involvement with the legal system including 'at high risk' for criminal behavior.
   - Continued substance use despite knowledge of physical or psychological problem(s) caused or exacerbated by the substance.
   - Impairment of judgment resulting in behavior that demonstrates substantial risk to self or others.
   - Maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system.
   - Substantial risk for or history of repeated treatment episodes of detox or crisis services.

- Objective signs of withdrawal from a substance.
- Substance use during pregnancy.
- Involvement with multiple social service agencies due to substance abuse.

--OR--

b. The individual has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, and does not currently meet the functional criteria. Without the supports/services provided, the individual would **likely** be unable to maintain his or her current level of recovery to the extent that his or her functioning would revert back to meeting the functional criteria.

F. DIAGNOSTIC CATEGORIES APPROVED FOR STATE FUNDED SERVICES

1. Adult Mental Health:

- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Adjustment Disorders (By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor or its consequences)
- Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
- Exclusions: **The following disorders are** *excluded* **unless co-occurring with a qualifying primary Axis I mental or substance related disorder that is the focus of treatment:**
  1) Tic disorders,
  2) Mental Retardation
  3) Learning Disorders
  4) Motor Skills Disorders
  5) Communication Disorders
  6) Organic Mental Disorders
  7) Pervasive Developmental Disorders
  8) Personality Change Due to a General Medical Condition
  9) Mental Disorder NOS Due to a General Medical Condition
  10) V Codes

2. Adult Addictive Diseases

- Substance-Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal.
- Note that severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
- **Exclusions:**
  1) Caffeine-Induced Disorders
  2) Nicotine-Related Disorders
  3) Substance Intoxication- only excluded for Ongoing Services.

***NOTE**: The presence of co-occurring mental illnesses, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation.*

*Consumers diagnosed with the excluded Axis I mental disorders listed above and/or with Axis II disorders may receive services **ONLY** when these disorders co-occur with a qualifying primary Axis I mental illness or substance related disorder. The qualifying Axis I mental illness or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the consumer must meet the functional criteria listed above.*

G. IMPLEMENTATION TIMEFRAME

The Core Customer criteria for state funded adult mental health and addictive disease services are effective **July 1, 2004**. Individuals receiving mental health and/or addictive disease services funded by the DHR, Division of Mental Health, Developmental Disabilities and Addictive Diseases must meet these criteria. Beginning July 1, 2004, all adults admitted to mental health or addictive disease services funded by DHR, DMHDDAD must meet the Core Customer criteria.

The provider is required to conduct an internal assessment of consumers' eligibility based on the Core Customer criteria and complete of the "DHR Adult Core Customer Eligibility Determination Form." This form is to be placed in the consumer's individual clinical record along with supporting documentation as verification of eligibility, and should be completed at the time of enrollment into services.

- For consumers who do not meet the Core Customer criteria based on the assessment, the provider may not serve such consumers using State funds, and may not report services rendered to such individuals in any service unit or individuals served counts used to fulfill contract obligations with the State.

H. CONTINUED REVIEW OF ELIGIBILITY

After **January 1, 2005**, **eligibility will be reviewed every 6 months** for consumers in state-funded services. Providers will be required to conduct internal reassessments of consumer eligibility based on the Core Customer criteria and complete the "DHR Adult Core Customer Eligibility Determination Form" every 6 months. This form is to be placed in the consumer's individual clinical record along with supporting documentation as verification of eligibility.

I. WAIVERS

In conformity with Division and Regional Office policy, regions may ask a contractor to serve a consumer who does not meet the eligibility criteria. Regional Offices may grant a waiver to the eligibility requirements.

CONSUMER ELIGIBILITY- CHILD AND ADOLESCENT CORE CUSTOMER
STATE FUNDED CHILD AND ADOLESCENT
MENTAL HEALTH AND ADDICTIVE DISEASE SERVICES

Overview of Core Customer Definitional Elements for Child and Adolescent Mental Health and Addictive Diseases State Funded Services:

1. The individual is under the age of 18, or is 18-21 years of age and either transitioning to adult services or remaining in child and adolescent services at least until the next Core Customer assessment because child and adolescent services are deemed more developmentally/clinically appropriate for the individual (i.e. for children still in high school, in DJJ or DFCS custody, or when otherwise developmentally/clinically indicated).
2. The child or adolescent must have a diagnosable emotional disturbance and/or substance related disorder on Axis I, in accordance with the latest edition of the DSM.
3. The child or adolescent's level of functioning must be significantly affected by the emotional disturbance and/or substance related disorder.

A. SERVICE ACCESS

Many individuals approach the state service delivery system looking for help. Not everyone who seeks assistance is in need of mental health or addictive disease services. In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment of the presenting circumstances is warranted.

1. Screening and Referral- Screening and referral are available for child and adolescent mental health and addictive disease services to **all individuals** under the age of 18 years old (18-21 in some circumstances).

For the purposes of this definition, **screening** refers to a brief assessment of an individual child's or adolescent's need for services to determine whether there are indications of an emotional disturbance and/or substance related disorder that warrant further evaluation. A screening may be initiated at any location:

- **a.** If the individual child or adolescent does not have indications of an emotional disturbance and/or substance related disorder, then an appropriate **referral** to other services or agencies is provided.
- **b.** If the individual child or adolescent does appear to have an emotional disturbance and/or substance related disorder, then core customer status is reviewed as a part of a comprehensive evaluation. The child/adolescent is referred to a designated agency in the service area for a comprehensive evaluation.

2. Comprehensive Evaluation- A **comprehensive evaluation** including diagnostic, functional and financial components is completed in accordance with accepted clinical practice and Division standards. Determination of core customer status for state funded

services is completed as a part of the comprehensive evaluation. Information gathered during the comprehensive evaluation is used to identify the treatment, and family supports needed by the child/adolescent and his/her family or caregiver.

B. CORE CUSTOMER CLASSIFICATION AND ELIGIBILITY DETERMINATION

There are three variables for consideration to determine whether a youth qualifies as a "core customer" for child and adolescent mental health and addictive disease services.

1. **Age-** An individual must be under the age of 18 years old. Individuals aged 18-21 years (children still in high school, in DJJ or DFCS custody or when it is otherwise developmentally/clinically indicated) may be served to assist with transitioning to adult services.

2. **Diagnostic Evaluation-** The state MHDDAD system utilizes the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system to identify, evaluate and classify an individual's type, severity, frequency, duration and recurrence of symptoms. The diagnostic evaluation must yield information that supports an emotional disturbance and/or substance related disorder primary diagnosis (or diagnostic impression) on Axis I in accordance with the latest edition of the DSM. The diagnostic evaluation must be documented adequately to support the diagnosis.

3. **Functional/Risk Assessment-** Information gathered to evaluate a child/adolescent's ability to function and cope on a day-to-day basis comprises the functional/risk assessment. Such information includes child and family resource utilization and the child's role performance, social and behavioral skills, cognitive skills, communication skills, personal strengths and adaptive skills, needs and risks as related to an emotional disturbance, substance related disorder or co-occurring disorder. The functional/risk assessment must yield information that supports a behavioral health diagnosis (or diagnostic impression) on Axis I in accordance with the DSM.

C. EARLY INTERVENTION AND STABILIZATION- CHILD AND ADOLESCENT MENTAL HEALTH AND ADDICTIVE DISEASES

The length of Early Intervention and Stabilization services is 12 visits or less (excluding the initial screening assessment).

Early Intervention: Indicates interventions taking place after a problem (e.g. an emotional disturbance and/or substance related disorder) is already suspected or identified, but that occur early enough to potentially avoid escalation of the problem into a crisis situation or into a chronic/significantly disabling disorder.

In order for an individual to qualify for **Child and Adolescent MENTAL HEALTH AND ADDICTIVE DISEASES EARLY INTERVENTION services,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.

2. **Functional-** The individual child/adolescent's level of functioning must meet at least one of the following criteria:

   a. is affected by an emotional disturbance or substance related disorder;
   b. has shown early indications of behaviors that could be disruptive to the community and the family/support system if behaviors intensified,
   c. has shown early indications behaviors/functional problems that could cause risk of removal from the home if problems intensified;
   d. has shown early indications of poor school performance (poor grades, disruptive behavior, lack of motivation, suspension);
   e. has shown early indications of delinquent behaviors that could result in legal system involvement; and/or
   f. has shown early indications of behavioral/functional problems that could result in multiple agency involvement if problems intensified.

Stabilization: Indicates interventions taking place after a problem has been identified (e.g. an emotional disturbance and/or substance related disorder) and has either developed into a crisis situation or become disabling enough to warrant at least short-term stabilization interventions.

In order for an individual to qualify for **Child and Adolescent MENTAL HEALTH AND ADDICTIVE DISEASES STABILIZATION services,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual child or adolescent must have a primary diagnosis or diagnostic impression on Axis I, consisting of an emotional disturbance and/or substance related disorder.

2. **Functional -** The individual child/adolescent's level of functioning must meet at least one of the following criteria:

   a. is significantly affected by a serious emotional disturbance or substance related disorder;
   b. results in behaviors that demonstrate a risk of harm to self, others, or property;
   c. causes a risk of removal from the home;
   d. results in school problems such as poor grades, school failure, disruptive behavior, lack of motivation, drop out, suspension or expulsion;
   e. results in legal system involvement;
   f. indicates the need for detoxification services; and/or
   g. is significantly disruptive to the community or the family/support system.

D. ONGOING SUPPORT AND TREATMENT- CHILD AND ADOLESCENT MENTAL HEALTH

Ongoing Support and Treatment: Indicates interventions taking place after an emotional disturbance of a severe and longer-term nature has been identified and has become disabling enough to warrant ongoing service provision to help support the child and family in order to improve the child's level of functioning and resilience. The length of Ongoing Support and Treatment services is anticipated to be longer than 12 visits (though how much longer varies by utilization guidelines, service needs and bio-psycho-social factors affecting functioning). An individual may either start out in Ongoing services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors.

For an individual/family to qualify for **Child and Adolescent MENTAL HEALTH ONGOING SUPPORT AND TREATMENT services,** certain diagnostic **and** functional criteria must be met, including the following:

1. **Diagnostic-** The individual child/adolescent must have a primary diagnosis of a serious emotional disturbance on Axis I, (*for example*: major depression, an anxiety disorder, or other serious emotional disturbance). *This must be a diagnosis, not just a diagnostic impression.* The disturbance must have persisted for at least one year or be likely to persist for at least one year without treatment, and must require ongoing, longer-term support and treatment services. Without such services, out of home placement or hospitalization is probable.

2. **Functional-** The individual child/adolescent's ability to function has been significantly affected by the serious emotional disturbance to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. Functional impairment must be demonstrated by *one of the following three indicators*:

   a. A total score of 60 or higher on the 8 subscales of the Child and Adolescent Functional Assessment Scale (CAFAS),

   --OR—

   b. Either a score of *20 or higher* (*moderate to severe impairment)* on the "Behavior Toward Others", the "Self-Harmful Behavior" or the "Thinking" CAFAS subscale, or a score of *30 (severe impairment)* on the "Moods/Emotions" CAFAS subscale,

   --OR--

b. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would *likely* be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

E. ONGOING SUPPORT AND RECOVERY- CHILD AND ADOLESCENT ADDICTIVE DISEASES

Ongoing Support and Recovery: Indicates interventions taking place after a substance related disorder has been identified and has become disabling enough to warrant ongoing service provision to assist in stabilizing/supporting the child and family, and to facilitate the child's recovery. The length of service is anticipated to be longer than 12 visits (though how much longer varies by utilization guidelines, service needs and bio-psycho-social factors affecting recovery). An individual may either start out in Ongoing services or be transitioned into this category at any point during or following Early Intervention and Stabilization services due to changes in clinical presentation, needs, circumstances or stressors.

For a person to qualify for **Child and Adolescent <u>ADDICTIVE DISEASES ONGOING SUPPORT AND RECOVERY</u> services,** certain diagnostic **<u>and</u>** functional criteria must be met, including the following:

1. **Diagnostic-** The child/adolescent must have a primary diagnosis on Axis I of a substance related disorder (excluding substance intoxication). Substances can refer to a drug of abuse, a medication or a toxin.[1] *This must be a diagnosis, not just a diagnostic impression.*

   1 Caffeine and nicotine are excluded.

2. **Functional-** The child/adolescent's ability to function has been significantly affected by the substance related disorder to the extent that there is impairment in ability to function at an age appropriate level and difficulty with age appropriate role performance. This functional difficulty must be demonstrated by *<u>one</u> of the following two indicators*:

   a. A score of 20 or higher (moderate to severe impairment) on the 'Substance Abuse" subscale of the Child and Adolescent Functional Assessment Scale (CAFAS).

   --OR--

   b. The child or adolescent has been in services for an extended period of time (six months or longer) with a qualifying Axis I diagnosis, but does not currently meet the functional criteria. Without the supports/services provided, the child/adolescent would likely be unable to maintain his or her current level of functioning to the extent that functioning would revert back to meeting the functional criteria.

F. Diagnostic Categories Approved for State Funded Services

1. Child and Adolescent Mental Health:
   - **Axis I disorders classified in the most recent version of the DSM.**
   - Note: By definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor *or* its consequences).
   - Exclusions: **The following disorders are *excluded* unless co-occurring with a qualifying primary Axis I emotional disturbance or substance related disorder that is the focus of treatment:**
     1) Tic disorders,
     2) Mental Retardation
     3) Learning Disorders
     4) Motor Skills Disorders
     5) Communication Disorders
     6) Organic Mental Disorders
     7) Pervasive Developmental Disorders
     8) V Codes
2. Child and Adolescent Addictive Diseases:
   - **Substance Related Disorders including but not limited to substance abuse, substance dependence, and substance withdrawal as classified in the most recent version of the DSM.**
   - Note that severity and duration of substance related disorders are not considered in regard to the Core Customer criteria (except as they may be inherent to the definition of a disorder).
   - **Exclusions:**
     1) Caffeine-Induced Disorders
     2) Nicotine-Related Disorders
     3) Substance Intoxication- only excluded for Ongoing Services.

NOTE: The presence of co-occurring emotional disturbances, substance related disorders and/or developmental disabilities is not uncommon and typically results in a more complicated clinical presentation.

Consumers diagnosed with the excluded Axis I disorders listed above and/or with Axis II disorders may receive services ONLY when these disorders co-occur with a qualifying primary Axis I emotional disturbance or substance related disorder. The qualifying Axis I emotional disturbance or substance related disorder must be the presenting problem and the primary diagnosis/focus of treatment, and the consumer must meet the functional criteria listed above.

G. IMPLEMENTATION TIMEFRAME

Beginning July 1, 2005, children and adolescents admitted to mental health or addictive disease services funded by the DHR, Division of Mental Health, Developmental Disabilities and Addictive Diseases must meet the Child and Adolescent Core Customer criteria. To ensure a smooth transition, there will be a phased in approach.

Consumers Enrolled in Services Prior to July 1, 2005: For existing consumers receiving DHR funded services, providers will have until June 30, 2005 to internally assess eligibility, and to transition individuals who do not meet eligibility criteria to other services/providers or to draw services to a conclusion.

- The provider is required to conduct an internal assessment of consumers' eligibility based on the Core Customer criteria and completion of the "DHR Child and Adolescent Core Customer Eligibility Determination Form," in Appendix 1. This form is to be placed in the consumer's individual clinical record along with supporting documentation as verification of eligibility. All internal assessments should to be completed by June 30, 2005.
- For those consumers who do not appear to meet the Core Customer criteria, the provider may continue to serve the consumers with funds from the DHR contract until June 30, 2005, or until the current course of treatment is completed whichever occurs first.
- For consumers who do not meet the Core Customer criteria based on the assessment and who remain in service after June 30, 2005, the provider may not serve such consumers using State funds, and may not report services rendered to such individuals in any "service unit" or "individuals served" counts used to fulfill contract obligations with the State.

New Consumers: For new consumers who present for services from July 1, 2005 forward:

The provider will be required to conduct an internal assessment of consumers' eligibility based on the Core Customer criteria and completion of the "DHR Child and Adolescent Core Customer Eligibility Determination Form." This form is to be placed in the consumer's individual clinical record as verification of eligibility and should be completed at the time of enrollment into services.

- For consumers who do not meet the Core Customer criteria based on the assessment, the provider may not serve such consumers using State funds, and may not report services rendered to such individuals in any "service unit" or "individuals served" counts used to fulfill contract obligations with the State.

H. CONTINUED REVIEW OF ELIGIBILITY

After July 1, 2005, eligibility will be reviewed every 6 months for consumers in state-funded services. Providers will be required to conduct internal reassessments of consumers' eligibility based on the Core Customer criteria and complete the "DHR Child and Adolescent Core Customer Eligibility Determination Form" every 6 months. This form is to be placed in the consumer's individual clinical record along with supporting documentation as verification of eligibility.

I. WAIVERS

In conformity with Division and Regional Office policy, regions may ask a contractor to serve a consumer who does not meet the eligibility criteria. Regional Offices may grant a waiver to the eligibility requirements.

II. Developmental Disabilities Services

To be eligible for **developmental disabilities services, consumers** must meet the following criteria for **"Most in Need"** or have received a waiver from the criteria by the Regional Office. Consumers who are **"Most in Need** " of services are those with social, emotional, developmental, or physical disabilities resulting from mental retardation or autism, who without State-supported services are unable to function. This group includes consumers who have a long history of dysfunction, consumers whose history and clinical status suggest a long-term course of service and consumers and their families with temporary but urgent need for intervention. The contractor will deliver services to individuals who meet the following disability/diagnostic criteria:

a. **Disability.** The individual demonstrates:

1. Behavior leading to public demand for intervention; or
2. Substantial risk of harm to self or others; or
3. Substantial inability to demonstrate community living skills at an age-appropriate level; or
4. Substantial need for supports to augment or replace insufficient or unavailable natural resources

AND

b. **Diagnosis**: Individual meets the following diagnostic criteria as determined by a professional licensed to do so:

1. People with mental retardation; or
2. People with autism.

The contractor agrees not to discontinue services to individuals who have only a diagnosis of autism or Prader Willi Syndrome who are receiving services from the contractor at the inception of this contract, except at the request of the consumer or his/her representative, or with the approval of the Regional Office, or upon the discontinuance of funding designated for such services by the Regional Office. Persons who are dually diagnosed with mental retardation or mental illness and autism or Prader Willi Syndrome are eligible for services.

III. Developmental Disabilities Family Support

For purposes of determining eligibility for Family Support Services for families having a family member with a developmental disability, the following definition of Developmental Disability applies:

Developmental disability **shall have the same meaning in 45 CFR Parts 1385, 1386, 1387, and 1388 as it does in the Developmental disabilities Act, Section 102(8), which reads:**

"the term 'developmental disability' means a severe, chronic disability of an individual 5 years of age or older that –

(1) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
(2) Is manifested before the individual attains age 22;
(3) Is likely to continue indefinitely;
(4) Results in substantial functional limitations in three or more of the following areas of major life activity –

    (i) Self-care;
    (ii) Receptive and expressive language;
    (iii) Learning
    (iv) Mobility
    (v) Self-direction;
    (vi) Capacity for independent living; and
    (vii) Economic self-sufficiency;

(5) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated, except that such term, when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided."

Such determination shall be made on case-by-case basis, and any State eligibility definition of developmental disability or policy statement which is more restrictive than that of the Act does not apply as the Act takes precedence.

IV. Prevention Programs

Eligible consumers include any individual, regardless of his or her ability to pay, who is physically located in the region at the time covered services are provided and meets the definition of ***"Target Population."*** The ***"Target Population"*** is defined as those individuals who have not been determined to require treatment for substance abuse and are members of the general population or sub-group at high risk for substance abuse and/or violence. Populations at risk include, among others, children of substance abusers, pregnant women, school dropouts and homeless and runaway youth.

Mental Health and Addictive Disease Services

Mental Health and Addictive Disease Services for Children and Adolescents

Activity Therapy
- Children and Adolescents

Definition of Service (Effective July 1, 2005 through December 31, 2005): Activity-based group or individual services which are treatment or goal-oriented and specifically designed to restore or maintain the functional abilities of individuals with cognitive, emotional, social or physical impairments. Modalities may include therapeutic recreation (e.g. leisure education and skill training including participating in community-based recreational activities; recreation participation; and wellness and healthy lifestyle education), music therapy, horticultural therapy, or one of the creative arts therapies. Types of activities offered are matched with individual needs, strengths, and preferences.

New Definition of Service (Effective January 1, 2006): The intentional and systematic use of recreational therapy, music therapy, art therapy, psychodrama, drama therapy, dance/movement therapy, biblio/poetry therapy, equestrian therapy, and/or horticultural therapy to treat the identified psychosocial, emotional, cognitive and rehabilitative needs of the individual. This service is offered for a maximum of 3 hours per day.

Expected outcomes for children and adolescents with serious emotional disturbances and/or substance- related diagnoses are improved interpersonal relationships and social skills, attention and concentration, ability to express feelings, and leisure functioning; reduced anxiety and tension; decreased aggressive behaviors; distraction from negative symptoms of mental illness; and strengthening of social/natural supports in the community.

Target Population	Children and Adolescents with SED and/or Substance Related Disorders	
Initial Authorization	STATE: (unit = 15 minutes)	MEDICAID: 360 units (unit = 15 minutes)
Re-Authorization	STATE: (unit = 15 minutes)	MEDICAID: 360 units (unit = 15 minutes)
Authorization Period	90 days	
MHMRIS: Subunit & Modality	Subunit 323 – Activity Therapy	Modality 08 – Outpatient
UAS: Budget and Expense Categories	C&A Activity Therapy Services 261 – Activity Therapy	
Medicaid:	Mental Health Y3011 – Activity Therapy Addictive Diseases Y3011 – Activity Therapy	

MH & AD SERVICES FOR CHILDREN AND ADOLESCENTS

Admission Criteria	1. Individual has primary behavioral health issues that are distressing (causing mental anguish or suffering) or destabilizing (markedly interfering with the ability to carry out daily activities or placing self/others in potential danger); **and one or more of the following:** 2. Individual lacks skill in the independent, successful use of leisure time, resulting in a barrier to community-based placement; **or** 3. Individual has received services through other services modalities and needs additional or different supports and/or structure.
Continuing Stay Criteria	1. Individual must have primary behavioral health issues that are distressing (causing mental anguish or suffering) or destabilizing (markedly interfering with the individual's ability to carry out daily activities or places self/others in potential danger); **and one or more of the following:** 2. Individual lacks skill in the independent, successful use of leisure time resulting in a barrier to community-based placement; **or** 3. Individual has received services through other service modalities and needs additional or different supports and/or structure. In addition, the individual must be showing progress toward resiliency goals as a result of initial activity therapy support.
Discharge Criteria	1. An adequate continuing care or discharge plan has been established **and one or more of the following:** 2. Individual no longer meets the admission criteria or continuing stay criteria; **or** 3. Goals of the Individualized Resiliency Plan have been substantially met; **or** 4. Individual and family request discharge, and the individual is not imminently dangerous; **or** 5. Transfer to another service/level of care is warranted by change in the individual's condition; **or** 6. Individual requires services not available through this modality of service; **or** 7. Individual is unwilling to comply with the program or is not making satisfactory progress toward service plan goals.
Service Exclusions	Not offered in conjunction with C&A Day Treatment or SA Adolescent Day Treatment.
Clinical Exclusions	1. Individual who requires one-to-one supervision for protection of self or others. 2. Individual is actively using unauthorized drugs or alcohol. 3. Individual with a psychiatric/addiction condition requiring a more intensive support/service.

A. Additional Service Criteria

B. Required Components

1. When group activity therapy is offered, the maximum face-to-face ratio cannot be more than 6 consumers to 1 direct service staff based on average daily attendance.

C. Staffing Requirements

1. The activity therapy service design for each individual must be approved by a credentialed professional in one of the specific disciplines listed below.
2. Effective through December 31 2005, the service must be provided by or under the direct supervision of a Mental Health Professional or a Substance Abuse Manager preferably credentialed in therapeutic recreation, horticulture therapy, music therapy, or one of the other creative arts therapies.
3. Effective January 1, 2006, Activity Therapy must be provided by a qualified professional therapist who meets the established training standards and credentialing requirements of one of the following associations:

    - Art Therapy – The Art Therapy Credentials Board
      Credential: A.T.R. or A.T.R.-BC
    - Biblio/Poetry Therapy – Federation for Biblio/Poetry Therapy
      Credential: CPT or RPT
    - Dance/Movement Therapy – American Dance Therapy Association
      Credential: DTR or ADTR
    - Music Therapy – Certification Board for Music Therapists
      Credential: MT-BC
    - Drama Therapy – National Association for Drama Therapy
      Credential: RDT
    - Horticultural Therapy – American Horticultural Therapy Association
      Credential: HTR or HTM
    - Psychodrama – The American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy
      Credential: CP or TEP
    - Recreational Therapy – National Council for Therapeutic Recreation Certification
      Credential: CTRS

D. Clinical Operations

1. Reimbursement for occasional therapeutic outings is allowed. The supporting documentation describing the individual's participation in the therapeutic outing must reflect the relationship of the activity to a specific goal in the Individualized Resiliency Plan. Billing for any therapeutic outing must remain within the daily maximums for this service and must be within the authorized amount of approved service for the individual being served.

2. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. While a combination of day supports in a group setting and one-to-one activity therapy is acceptable if ordered as part of the Individualized Resiliency Plan, it is subject to retrospective review.

E. Service Access

F. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

G. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

DAY SUPPORTS
- CHILDREN AND ADOLESCENTS

Definition of Service: (No new providers. Discontinued by all current providers effective July 1, 2006): Support services provided to children and adolescents, and their families/responsible caregiver(s) with the primary goals of restoring, developing, enhancing or maintaining the child/adolescent consumer's/family unit's level of functioning. Support services provided include an integrated set of educational, skill building, leisure and socialization training for the child/adolescent consumer, as well as parental psychoeducation/training. Individuals will have access to supports designed to build age appropriate functioning that will result in family and community living. The program must demonstrate operational flexibility such that individuals and families/responsible caregiver(s) can access supports as needed. The program must accommodate the individual's school participation. It is expected that hours during holidays and summer are more expansive. This service is offered for a maximum of 5 hours per day.

Target Population	Children & Adolescents with SED and/or Substance-Related Disorders
Initial Authorization	600 units (unit = 1 hour)
Re-Authorization	600 units (unit = 1 hour)
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit: 340 – Day Supports for Children Services Modality: 07 – Day Patient
UAS: **Budget and Expense Categories**	C&A Day Services 257 – Day Supports
Medicaid:	Mental Health Y3025 – Child and Adolescent Day Supports Addictive Diseases Y3025 – Child and Adolescent Day Supports
Admission Criteria	1. Individual has primary behavioral health issues that are distressing (causing mental anguish or suffering) or destabilizing (markedly interfering with the ability to carry out daily activities or placing self/others in potential danger); **or** 2. Individual, through assessment, demonstrates the need for supports around socialization, leisure skills, and behavioral concerns. The absence of natural supports related to the behavioral health issue can be an indicator for service authorization.

Continuing Stay Criteria	1. Individual demonstrates some improvement in functioning through the development of natural supports, and leisure and socialization skills has not achieved all major resiliency goals identified in this area; **or** 2. Individual, in the absence of these supports, would demonstrate reduced ability in functioning and behavioral adaptation.
Discharge Criteria	1. Goals of the Individualized Resiliency Plan have been substantially met; **or** 2. Individual and family requests discharge from the support services; or 3. Transfer to another service is warranted by change in the individual's behavioral health condition.
Service Exclusions	Not offered at the same time as SA Adolescent Day Treatment, or C&A Day Treatment, except in cases of transition planning.
Clinical Exclusions	1. Individual who requires one-to-one supervision for protection of self or others. 2. Individual with severe clinical issues that preclude provision of services at this level of care. 3. Individual with any of the following conditions unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder 4. Individual is actively using unauthorized drugs or alcohol.

Additional Service Criteria:

A. Required Components

1. This service may operate in the same building as other day services under this rehab option, however, there must be a distinct separation between services in staffing, program description, and physical space.
2. Programming must complement and coordinate with the school system and/or DFCS, DJJ as clinically necessary.

B. Staffing Requirements

1. Maximum face-to-face ratio cannot be more than 6 consumers to 1 direct service staff based on average daily attendance.
2. The program must be under the supervision of a Mental Health Professional or, as appropriate, a Substance Abuse Manager.
3. The service must be provided by at least 1 Mental Health Professional or Substance Abuse Professional with at least 2 years of experience in child-specific behavioral health services.

C. Clinical Operations

1. Involvement of parents/caretakers is essential in the provision of specialized day services for children and adolescents and is a necessary tool in enabling the individual to move to less restrictive services. This requirement, however, should not be allowed to become a barrier to the delivery of services to individuals whose parent/s or caretaker/s are not able to participate or are not available.
2. Because of the nature of this service and the component of leisure and recreational skills development, reimbursement for occasional therapeutic outings is allowed. The supporting documentation describing the individual's participation in the therapeutic outing must reflect the relationship of the activity to a specific goal in the Individualized Resiliency Plan. Staff ratios for the service must be maintained. Billing for any therapeutic outing must be within the daily maximums for this service and must be within the authorized amount of approved service for the individual being served.
3. When this service is offered to children and adolescents with substance abuse issues as well as mental health concerns, the program design should address the unique needs of individuals with co-occurring disorders.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In addition to other documentation and reporting requirements, there must be, at minimum, a weekly activity note that summarizes the individual's progress and/or lack of progress. Documentation of daily attendance is also required.

INTENSIVE FAMILY INTERVENTION -CHILDREN AND ADOLESCENTS

Definition of Service: A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified individual consumer. Services are delivered utilizing a team approach and are provided primarily to children (i.e. the consumers) in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Diffuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensure linkage to needed community services and resources; and
- Improve the individual child's/adolescent's ability to self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

Services should include crisis intervention, intensive case management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive assessment and are directed towards the identified individual and his or her behavioral health needs and goals as identified in the Individualized Resiliency Plan. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. An example of a related best/evidence based practice is Multi-Systemic Therapy (MST).

Target Population	Children and Adolescents with SED and/or Substance Related Disorders
Initial Authorization	576 units (unit = 15 minutes)
Re-Authorization	Continued Stay Review is required after 12 weeks.
Authorization Period	90 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 362 – Intensive Family Intervention — 08 – Outpatient
UAS: **Budget and Expense Categories**	C&A Intensive Treatment Services 253 – Intensive Family Intervention
Medicaid:	Mental Health Y3033 – Intensive Family Intervention Addictive Diseases Y3033 – Intensive Family Intervention

Admission Criteria	1. Individual has a diagnosis and duration of symptoms which classify the illness as SED and/or is diagnosed Substance Related Disorder; **and one or more of the following:** 2. Individual has received services through other services modalities and needs additional or different supports and/or structure. Treatment at a lower intensity has been attempted or given serious consideration; **or** 3. Individual and/or family has insufficient or severely limited resources or skills necessary to cope with an immediate behavioral health crisis; **or** 4. Individual and/or family behavioral health issues are unmanageable in traditional outpatient treatment and require intensive, coordinated clinical and supportive intervention; **or** 5. Because of behavioral health issues, the individual is at immediate risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent; **or** 6. Because of behavioral health issues, the individual is at immediate risk of legal system intervention or is currently involved with DJJ.
Continuing Stay Criteria	1. Same as above.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** Individual no longer meets the admission criteria; **or** 2. Goals of the Individualized Resiliency Plan have been substantially met; **or** 3. Individual and family request discharge, and the individual is not imminently dangerous; **or** 4. Transfer to another service is warranted by change in the individual's condition; **or** 5. Individual requires services not available within this service.
Service Exclusions	Not offered in conjunction with Individual Counseling, Family Counseling/Training, Crisis Intervention Services, Community Support Individual, Community Support Team, and/or Crisis Residential.
Clinical Exclusions	1. Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury 2. Individual can effectively and safely be treated at a lower intensity of service.

Additional Service Criteria:

A. Required Components:

1. The organization has established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
2. Each IFI provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
3. The organization must have an Intensive Family Intervention Organizational Plan that addresses the description of:
    - Particular family preservation, case management, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff.
    - Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated.
    - Hours of operation, the staff assigned, and types of services provided to consumers, families, parents, and/or guardians
    - How the plan for services is modified or adjusted to meet the needs specified in each Individualized Resiliency Plan and
      Description of how the team works with the family and other agencies/support systems to build a clinically oriented transition and discharge plan.
4. At least 60% of services must be provided face-to-face with children and their families, and 80% of all face-to-face services must be delivered in non-clinic settings over the authorization period.
5. At least 50% of IFI face-to-face contacts must include the child (identified consumer). However, when the child is not included in the face-to-face contacts, the focus of the contacts must remain on the child and their goals as identified on their IRP.

B. Staffing Requirements

1. Intensive Family Intervention is provided by a team consisting of the family and the following practitioners:
    - One fulltime Team Leader who is licensed (and/or certified as a CAC II if the target population is solely diagnosed with substance related disorders) by the State of Georgia under the Practice Acts and has at least 3 years of experience working with children with serious emotional disturbances. LAMFT, LMSW, LAPC staff do not qualify for this position. Team leaders who are employed February 2005 in this position and have an associate license may remain in this position if they are in active pursuit of the full clinical licensure. In this instance, team leaders must be licensed by July 2007.
    - Two to three fulltime equivalent paraprofessionals who work under the supervision of either a Mental Health Professional or a Substance Abuse Manager.

- The team may also include an additional Mental Health Professional or Substance Abuse Professional.

2. For those families who require it, the Intensive Family Intervention Team must have access to psychiatric and psychological services, as provided by a Psychiatrist or a Licensed Psychologist.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice components/models are multisystemic therapy, multidimensional family therapy, and others as appropriate to the child, family and issues to be addressed.
4. The IFI Team's family-to-staff ratio must not exceed 12 families for teams with two paraprofessionals, and 16 families for teams with three paraprofessionals (which is the upper limit) any given time. The staff-to-family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

B. Clinical Operations:

1. In-home services include consultation with the individual, parents, or other caregivers regarding medications, behavior management skills, and dealing with the responses of the individual, other caregivers and family members, and coordinating with other child-serving treatment providers.
2. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual or family develops strengths and coping skills.
3. Intensive Family Intervention must be provided through a team approach (as evidenced in documentation) and flexible services designed to address concrete therapeutic and environmental issues in order to stabilize a situation quickly. Services are family focused, active and rehabilitative, and delivered primarily in the home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the individual's functioning.
4. Service delivery must be preceded by a thorough assessment of the child and the family in order to develop an appropriate and effective treatment plan.
5. IFI services provided to children and youth must be coordinated with the family and significant others and with other systems of care such as the school system, the juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
6. IFI providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive, and foster), schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights

and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).

7. The organization must have policies that govern the provision of services in natural settings and can document that it respects the individual's and/or family's right to privacy and confidentiality when services are provided in these settings
8. When a projected discharge date for the service has been set, the child may begin to receive Community Support Individual or Team services two weeks prior to IFI discharge for continuity of care purposes only.
9. IFI recipients can receive limited Group Training/Counseling (up to 8 units/week) when a curriculum-based therapeutic group is offered. For this to be allowable, the IFI participants must have clinical needs and resiliency goals which justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than 4 IFI participants at one time and must be directed by no fewer than 2 staff in order to be billed as Group Training/Counseling. This may be offered for no more than 2 hours in any given week. Only IFI consumers are permitted to attend these group services.

C. Service Accessibility:

1. Services must be available 24 hours a day, 7 days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention.
2. Due to the intensity of the service providers must offer a minimum of 3 contacts per week with the consumer/family.

D. Additional Medical Requirements:

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

E. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

MENTAL HEALTH DAY TREATMENT - CHILDREN AND ADOLESCENTS

Definition of Service: Specialized after-school and weekend group-based services including counseling (individual, group, family), parent/consumer education, skill/leisure/socialization training which focus on the amelioration of functional and behavioral deficits resulting from an emotional disturbance or co-occurring disorder. Services are to be available at least 5 days per week to allow individuals' access to supports and treatment deemed necessary to build the individual's age-appropriate functioning within the community and family. Intense coordination/linkage with schools and other child serving agencies is mandatory. Child and Adolescent Mental Health Day Treatment provides stabilization of psychiatric concerns and promotes resiliency incorporating the basic tenets of clinical practice. This service is offered for a minimum of 2 hours per day and a maximum of 5 hours per day.

The programmatic goals of the service must be clearly articulated by the provider, utilizing population and issue-specific best/evidence based practices for service delivery and support (including addressing both mental health and co-occurring substance related disorders/issues). Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Some examples of best/evidence based practice models/components are Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, family education/training, and others as appropriate to the population(s) and issues to be addressed. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical services provided by a multidisciplinary team, and are directed towards the identified individual consumer and his or her behavioral health needs based upon the Individualized Resiliency Plan.

***Note:** This service will be modified for July 1, 2006 to be blended with C&A Day Supports.

Target Population	Children and Adolescents with SED Children and Adolescents with SED and Co-Occurring Substance Related Disorders.
Initial Authorization	450 units (unit = 1 hour)
Re-Authorization	450 units (unit = 1 hour)
Authorization Period	90 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 334 – Day Treatment for Children — 07 – Day Patient
UAS: **Budget and Expense Categories**	C&A Day Services 256 – C&A Mental Health Day Treatment
Medicaid:	Mental Health Y3018 – Child and Adolescent Day Treatment

Admission Criteria	1. Individual can reasonably be expected to show demonstrable improvement within 6 months; **and one or more of the following:** 2. Individual must have incapacitating mental health issues that interfere with the ability to carry out daily activities and/or place others in danger to the point of causing anguish or suffering; **or** 3. Individual's clinical and behavioral issues are unmanageable in traditional outpatient treatment and require intensive, coordinated multidisciplinary intervention within a therapeutic milieu; **or** 4. Individual's level of functioning precludes provision of services in less restrictive services/supports and includes deficits in daily living skills, social skills, vocational/academic skills, and community/family integration.
Continuing Stay Criteria	1. If services are discontinued there would be an increase in the severity of the presenting problems; **or** 2. Progress notes document progress relative to goals identified in the Individualized Resiliency Plan, but the goals are not yet met.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Resiliency Plan have been substantially met; **or** 3. Individual and family request discharge, and the individual is not imminently dangerous; **or** 4. Transfer to another service/level of care is warranted by change in the individual's condition; **or** 5. Individual requires services not available in this level of care.
Service Exclusions	Not offered at the same time as SA Adolescent Day Treatment, Activity Therapy or C&A Day Supports
Clinical Exclusions	1. Individual who requires one-to-one supervision for protection of self or others; **or** 2. Individual with severe clinical issues that preclude provision of services at this service intensity; **or** 3. Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder d. Primary Substance Abuse Problems; **or** 4. Individual is actively using unauthorized drugs or alcohol; **or** 5. Individual can effectively and safely be treated at a lower intensity of service.

Additional Service Criteria:

A. Required Components:

1. The service must operate at an established clinic site. However, appropriate therapeutic recreational activities may take place off-site in natural community settings in accordance with an individual's specific resiliency goal(s)
2. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space.
3. Programming must complement and coordinate with the school system and/or DFCS, DJJ as clinically necessary.

B. Staffing Requirements

1. Maximum face-to-face ratio cannot be more than 4 consumers to 1 direct service staff based on average daily attendance.
2. The program is under the supervision of a Mental Health Professional.
3. The staff consists of at least 50% Mental Health Clinicians and/or Mental Health Professionals.
4. While SAP/SAM staff are not required for this service, the agency offering services to children and adolescents with co-occurring MH/AD issues must document that at least one staff have either experience in serving this population or have received 4 hours of co-occurring competency training within the last 2 years. This documentation shall be maintained in staff personnel records.

C. Clinical Operations

1. Transition planning for less intensive service options is expected to begin at the onset of this service delivery. Documentation must demonstrate this planning.
2. While Family Training and Individual Counseling are included in this service, Family Therapy may be offered as a separate and concurrent service.
3. Involvement of parents/caretakers is essential in the provision of specialized day services for children and adolescents and is a necessary tool in enabling the individual to move to less restrictive services. This requirement, however, should not be allowed to become a barrier to the delivery of services to individuals whose parent/s or caretaker/s are not able to participate or are not available.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In addition to other reporting requirements, daily progress notes are required because of the intensity of this service.

SUBSTANCE ABUSE DAY TREATMENT - CHILDREN AND ADOLESCENTS

Definition of Service: Specialized after-school and weekend group-based services including counseling (individual, group, family), parent/consumer education, skill and socialization training which focus on the amelioration of functional and behavioral deficits resulting from a substance related disorder. Services are to be available at least 5days per week to allow individuals' access to supports and treatment deemed necessary to build the individual's age-appropriate functioning within the community and family. Intense coordination/linkage with schools and other child serving agencies is mandatory. This service promotes resiliency and recovery from substance use disorders incorporating the basic tenets of clinical practice. This service is offered for a minimum of 2 hours per day and a maximum of 5 hours per day.

The programmatic goals of the service must be clearly articulated by the provider, utilizing population and issue-specific best/evidence based practices for service delivery and support. Some examples of best/evidence based practice models/components are Motivational Interviewing/Enhancement, Behavioral Family Therapy, Functional Family Therapy, Brief Strategic Family Therapy, Cognitive Behavioral Therapy, and others as appropriate to the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices in adolescent substance abuse treatment. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical services provided by a multidisciplinary team, and are directed towards the identified individual consumer and his or her behavioral health needs based upon the Individualized Resiliency Plan.

Target Population	Adolescents with Substance Related Disorders Adolescents with primary Substance Related Disorders and Co-Occurring SED
Initial Authorization	450 units (unit = 1 hour)
Re-Authorization	450 units (unit = 1 hour)
Authorization Period	90 days
MHMRIS: **Subunit & Modality**	Subunit: 762 – Substance Abuse Adolescent Day Treatment Modality: 07 – Day Patient
UAS: **Budget and Expense Categories**	C&A Day Services 856 – C&A Substance Abuse Day Treatment
Medicaid:	Addictive Diseases Y3020 – Adolescent Substance Abuse Day Treatment

Admission Criteria	1. Individual meets the diagnostic criteria for Substance-Related Disorder as defined by the current DSM or other standardized and widely accepted criteria; **and** 2. Individual meets the age criteria for adolescent treatment; **and** 3. Individual's biomedical conditions and problems, if any, are stable or are being concurrently addressed; **and one or more of the following:** a. Individual is currently unable to maintain behavioral stability for more than a 72-hour period, as evidenced by distractibility, negative emotions, or generalized anxiety; **or** b. Individual has a diagnosed emotional/behavioral disorder that requires monitoring and/or management due to a history indicating a high potential for distracting the individual from recovery **or** treatment; **or** c. There is a likelihood of drinking or drug use without close monitoring and structured support. *See also ASAM Level II treatment criteria.*
Continuing Stay Criteria	1. Individual continues to meet admission criteria 1, 2, and 3; and 2. Individual is responding to treatment as evidenced in progress toward goals, but has not yet met the full expectation of the objectives; **or** 3. Individual is beginning to recognize and understand his/her responsibility for addressing his/her illness, but still requires services and strategies to sustain personal responsibility and progress in treatment; **or** 4. Individual recognizes and understands relapse triggers, but has not developed sufficient coping skills to interrupt or postpone gratification or to change related inadequate impulse-control behaviors; **or** 5. Individual's substance-seeking behaviors, while diminishing, have not been reduced sufficiently to support functioning outside of a structured treatment environment. *See also ASAM Level II continued service criteria.*
Discharge Criteria	1. Adequate continuing care plan has been established; **and one or more of the following**: 2. Individual exhibits symptoms of acute intoxication and/or withdrawal and requires treatment at a more intensive level of service; **or** 3. Individual's problems have diminished in such a way that they can be managed through less intensive services; **or** 4. Individual has a confounding medical/behavioral issue interfering with addiction treatment; **or** 5. Individual recognizes the severity of his/her alcohol and other drug problem and is beginning to apply the skills necessary to maintain recovery by accessing appropriate community supports or by continuing treatment in a less intensive level of

	are; **or** 6. Individual has consistently failed to achieve essential treatment objectives despite revisions to the treatment plan and advice concerning the consequences of continued alcohol/drug use to such an extent that no further progress is likely to occur. *See also ASAM Level II discharge criteria.*
Service Exclusions	Not offered at the same time as Day Supports or Mental Health Day Treatment. Activity Therapy may not be offered as a discrete billable service, but may be included within this service package.
Clinical Exclusions	1. Individual manifests overt physiological withdrawal symptoms; **or** 2. Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components:

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. The service is offered at an established clinic site.
3. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space.

B. Staffing Requirements

1. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average daily attendance.
2. The program must be under the supervision of a Substance Abuse Manager.
3. The staff consists of at least 50% Substance Abuse Professionals.
4. Staff must have the knowledge of the developmental needs of youth and the program must be geared toward their interests and needs.

C. Clinical Operations

1. The program includes the availability of the following activities/training based on the individual's need and the targeted goals for treatment:
    - Age-appropriate individual education regarding substance abuse and addiction, the recovery process and relapse prevention
    - Introduction to the use of self-help groups (AA, NA, etc.)

- Group and Individual counseling/training including groups for targeted clinical needs
- Leisure and social skills with emphasis on how to handle leisure time without drinking or using drugs
- Interpersonal skills building including family communications and developing relationships with healthy individuals
- Simulated community living skills

2. There is a planned program for families that includes education regarding the disease concept and the impact of addiction on the family, the recovery process and relapse prevention, and introduction to self-help groups. Family services address adolescent developmental issues, especially those that may impact recovery, and requirements for maintaining abstinence.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. In addition to other reporting requirements, there is at minimum a weekly activity note that summarizes the individual's progress or lack of progress toward goals identified in the Individualized Resiliency Plan. Documentation of daily attendance is also required for billing purposes.

Mental Health and Addictive Disease Services for Children, Adolescents and Adults

AMBULATORY SUBSTANCE DETOXIFICATION

Definition of Service: This service is the medical monitoring of the physical process of withdrawal from alcohol or other drugs in an outpatient setting for those individuals with an appropriate level of readiness for behavioral change and level of community/social support. It is indicated when the individual experiences physiological dysfunction during withdrawal, but life or significant bodily functions are not threatened.

This service must reflect ASAM (American Society of Addiction Medication) Levels I-D (Ambulatory Without Extended On-Site Monitoring) and II-D (Ambulatory With Extended Onsite Monitoring) and focuses on rapid stabilization and entry into the appropriate level of care/treatment based upon the ASAM guidelines placement criteria. These services may be provided in traditional Outpatient, Intensive Outpatient, Day Treatment, Intensive Day Treatment or other ambulatory settings.

Target Population	Adults and Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0	
Initial Authorization	State: Episode of Care	Medicaid: 60 units (unit = 15 minutes)
Re-Authorization	State: Episode of Care	Medicaid: 60 units (unit = 15 minutes)
Authorization Period	30 days	
MHMRIS: **Subunit & Modality**	Subunit 780 – Ambulatory Detoxification	Modality 08 – Outpatient
UAS: **Budget and Expense Categories**	Substance Abuse Detox Services Provider – Ambulatory Detox 766 – Adult Addictive Diseases 866- C&A Addictive Diseases	
Medicaid:	Addictive Diseases Y3005 – Ambulatory Detoxification	
Admission Criteria	Individual has a Substance Induced Disorder (ASAM PPC-2, Dimension-1) that is incapacitating, destabilizing or distressing. If the severity is incapacitating, there must be sufficient optimization in other dimensions of the individual's life to provide for safe detoxification in an outpatient setting, and individual meets the following three criteria: 1. Individual is experiencing signs and symptoms of withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that	

	withdrawal is imminent; and the individual is assessed to be at minimal (Level I-D) to moderate (Level II-D) risk of severe withdrawal syndrome outside the program setting and can safely be managed at this service level; and 2. Individual has no incapacitating physical or psychiatric complications that would preclude ambulatory detox services; and 3. Individual is assessed as likely to complete needed detoxification and to enter into continued treatment or self-help recovery as evidenced by: 1) Individual or support persons clearly understand and are able to follow instructions for care, and 2) Individual has adequate understanding of and expressed interest to enter into ambulatory detox services, or 3) Individual has adequate support services to ensure commitment to completion of detoxification and entry into ongoing treatment or recovery, or 4) Individual evidences willingness to accept recommendations for treatment once withdrawal has been managed.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can participate in self-directed recovery or ongoing treatment without the need for further medical or detoxification monitoring.
Discharge Criteria	1. Adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery Plan have been substantially met.; or 3. Individual/family requests discharge and individual is not imminently dangerous; or 4. Withdrawal signs and symptoms have failed to respond to treatment and have intensified (as confirmed by higher scores on CIWA-Ar or other comparable standardized scoring system) such that transfer to a more intensive level of detoxification service is indicated, or 5. Individual has been unable to complete Level I-D/II-D despite an adequate trial.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Ambulatory Detoxification is not to be billed separately as Medication Administration.)
Clinical Exclusions	1. Substance Abuse issue has incapacitated the individual in all aspects of daily living, there is resistance to treatment as in ASAM Dimension 4, relapse potential is high (Dimension 5), and the recovery environment is poor (Dimension 6). 2. Concomitant medical condition and/or other behavioral health issues warrant inpatient/residential treatment.

Additional Service Criteria

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate ambulatory detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.
3. Programmatic philosophy must reflect emphasis on the development of a Plan of Care, which provides services in the least restrictive most empowering setting. This is an essential consideration for each individual's plan of care. This empowers individuals by fostering independence.

B. Staffing Requirements

1. Services must be provided only by nursing or other licensed medical staff under supervision of a physician.

C. Clinical Operations

1. The severity of the individual's symptoms, level of supports needed, and the physician's authorization for the service will determine the setting, as well as the amount of nursing and physician supervision necessary during the withdrawal process. The individual may or may not require medication, and 24-hour nursing services are not required. However, there is a contingency plan for "after hours" concerns/emergencies.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

COMMUNITY BASED INPATIENT PSYCHIATRIC AND SUBSTANCE DETOXIFICATION SERVICES

Definition of Service: A short-term stay in a licensed and accredited community-based hospital for the treatment or habilitation of a psychiatric and/or substance related disorder. Services are of short duration and provide treatment for an acute psychiatric or behavioral episode. This service may also include Medically Managed Inpatient Detoxification at ASAM Level IV-D.

Target Population	Children, Adolescents and Adults with SED/a serious mental illness Children, Adolescents and Adults with a Substance Related Disorder Children, Adolescents and Adults with Co-occurring SED/SMI and a Substance Related Disorder
Initial Authorization	5 days
Re-Authorization	3 days
Authorization Period	5 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 336 – Community Based Inpatient Services — 01 – Inpatient Subunit — Modality 710 – Community Based Inpatient Detox — 01 - Inpatient
UAS: **Budget and Expense Categories**	Crisis Services Provider Community Based Inpatient/Detox 135 – Adult Mental Health 235 – C&A Mental Health 735 – Adult Addictive Diseases 835 – C&A Addictive Diseases
Medicaid:	NONE
Admission Criteria	1. Individual with serious mental illness/SED that is experiencing serious impairment; persistent, recurrent, severe, or major symptoms (such as psychoses); or who is experiencing major suicidal, homicidal or high risk tendencies as a result of the mental illness; or 2. Individual's need is assessed for 24/7 supports which must be one-on-one and may not be met by any service array which is available in the community; or 3. Individual is assessed as meeting diagnostic criteria for a Substance Induced Disorder according to the latest version of the DSM; and one or more of the following: A. Individual is experiencing signs of severe withdrawal, or

	there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; or B. Level IV-D is the only available level of service that can provide the medical support and comfort needed by the individual, as evidenced by: A detoxification regimen or individual's response to that regimen that requires monitoring or intervention more frequently than hourly, or The individual's need for detoxification or stabilization while pregnant, until she can be safely treated in a less intensive service.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; and 2. Individual's withdrawal signs and symptoms are not sufficiently resolved to the extent that they can be safely managed in less intensive services;
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Individual no longer meets admission and continued stay criteria; or 3. Individual/family requests discharge and individual is not imminently dangerous to self or others; or 4. Transfer to another service/level of care is warranted by change in the individual's condition; or 5. Individual requires services not available in this level of care.
Service Exclusions	This service may not be provided simultaneously to any other service in the service array excepting short-term access to services that provide continuity of care or support planning for discharge from this service.
Clinical Exclusions	Individuals with any of the following unless there is clearly documented evidence of an acute psychiatric/addiction episode overlaying the primary diagnosis: a. Autism b. Mental Retardation/Developmental Disabilities c. Organic Mental Disorder; or d. Traumatic Brain Injury

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2

2. A physician's order in the individual's record is required to initiate detoxification services. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

1. Detoxification services must be provided only by nursing or other licensed medical staff under supervision of a physician.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service.

F. Reporting Requirements

1. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.

COMMUNITY SUPPORT – INDIVIDUAL

Definition of Service: Community Support services consist of rehabilitative, environmental support and targeted case management considered essential to assist an individual in gaining access to necessary services and in restoring him or herself to the best possible functional level with the greatest degree of life quality enhancement, self efficacy and recovery/resiliency, illness self-management, and symptom reduction possible. The service activities of Community Support include:

- Assistance to the individual in the development and coordination of the Individual Recovery/Resiliency Plan (IRP);
- Support and intervention in crisis situations;
- Assistance to the individual in the development of advanced directives related to his/her behavioral healthcare; and
- Individualized interventions, which shall have as objectives:
  1) Identification, with individual, of strengths which may aid the individual in recovery, as well as barriers that impede the development of skills necessary for independent functioning in the community;
  2) Support to facilitate recovery (including support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
  3) For those who have achieved a level of recovery stability, support to maintain recovery;
  4) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and work environments);
  5) Encouraging the development and eventual succession of natural supports in workplace and school environments;
  6) Assistance in the acquisition of symptom monitoring and illness self-management skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed) in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living;
  7) Assistance with financial management skill development;
  8) Assistance with personal development and school/work performance;
  9) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the individual's disability;
  10) Service and resource coordination to assist the individual in gaining access to necessary rehabilitative, medical and other services;
  11) Assistance to individuals with illness self-management as it relates to maintaining employment and school tenure; and
  12) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

13) Identification, with individual, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

When the service is provided by a Certified Peer Specialist, the above functions/interventions should be performed with a special emphasis on recovery values and processes such as:

1) Empowering the individual to have hope for and participate in his or her own recovery;
2) Helping the individual identify strengths and needs related to attainment of independence in terms of skills, resources, and supports, and to use available strengths, resources and supports to achieve independence;
3) Helping the individual to identify and achieve their personalized recovery goals (which should include attainment of meaningful employment if desired by the individual); and
4) Promoting an individual's responsibility related to illness self-management.

This service is provided to individuals to maintain stability and independence in their daily community living. Stability is measured by a decreased number of hospitalizations and by decreased frequency and duration of crisis episodes. Supports based on the individual's needs and satisfaction are used to sustain recovery from the debilitating effects of mental illness and substance abuse and to increase independent daily functioning. The Community Support staff will serve as the primary coordinator of behavioral health services and will provide linkage to community; general entitlements; and psychiatric, addiction, medical services, crisis prevention and intervention services.

Target Population	Children, Adolescents and Adults with one of the following: Mental Health Diagnosis Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Health Diagnosis, Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/ Developmental Disabilities
Initial Authorization	600 units (unit = 15 minutes)
Re-Authorization	Continued Stay Review is required every 180 days.
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 361 – Community Support Individual — 08 – Outpatient 261 – Community Support Individual - TRIS/LOC Program — 14 – TRIS/LOC

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

UAS: **Budget and Expense Categories**	Core Services Provider 126 – Adult Mental Health 226 – C&A Mental Health 726 – Adult Addictive Diseases 826 – C&A Addictive Diseases MATCH/TRIS/LOC Specific 127 – Adult Mental Health 227 – C&A Mental Health 727 – Adult Addictive Diseases 827 – C&A Addictive Diseases Employment Services Provider 140 – Adult Mental Health 240 – C&A Mental Health 740 – Adult Addictive Diseases 840 – C&A Addictive Diseases
Medicaid:	Mental Health Y3030 – Community Support Individual Addictive Diseases Y3030 – Community Support Individual
Admission Criteria	1. Individual must meet target population criteria as indicated above; **and one or more of the following:** 2. Individual may need assistance with developing, maintaining, or enhancing social supports or other community coping skills; **or** 3. Individual may need assistance with daily living skills including coordination to gain access to necessary rehabilitative and medical services
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Individual demonstrates documented progress or maintenance of community skills relative to goals identified in the Individualized Recovery/Resiliency Plan.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of Individualized Recovery/Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and the individual is not imminently in danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in the individual's condition.
Service Exclusions	ACT, Intensive Family Intervention, Community Support-Team

Clinical Exclusions	1. There is a significant lack of community coping skills such that a more intensive service is needed. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: • mental retardation • autism • organic mental disorder, or • Traumatic brain injury

Additional Service Criteria:

A. Required Components

1. Community Support services must include a variety of interventions in order to assist the consumer in developing:
    - Symptom self-monitoring and self-management of symptoms
    - Strategies and supportive interventions for avoiding out-of-home placement for adults and children and building stronger family support skills and knowledge of the adult, child or youth's strengths and limitations
    - Relapse prevention strategies and plans
2. Community Support Services focus on building and maintaining a therapeutic relationship with the individual and facilitating treatment and recovery goals.
3. The organization must have policies and procedures for protecting the safety of staff who engage in these community-based service delivery activities.
4. Individuals receiving Community Support Services must be seen face-to-face a minimum of once every 30 days. Individuals must also receive a telephone check in call once a month unless there have been 2 or more face-to-face contacts within the community. If the targeted individual is a child or adolescent, the contact may be made with the child and/or family based upon clinical appropriateness. The child/adolescent consumer of service must clearly remain the target of service.
5. At lease 60% of community support services must be delivered face-to-face with consumers, and at least 80% of all face-to-face services must be must be delivered in non-clinic settings over the authorization period. Services delivered to consumers who are receiving medication management only or Children's LEVEL OF CARE program, services are not counted in the minimum offsite service requirement. The Community Support - Individual provider, through documentation, must demonstrate that a significant effort has been made to make a face-to-face contact with the consumer outside the agency; however, when multiple attempts made to contact consumer have failed and have been documented, Community Support - Individual may still be billed.
6. When Community Support - Individual, supports consumers participating in medication management as the primary focus of service, the following allowances apply:

- These consumers are not counted in the offsite service requirement or the consumer-to-staff ratio.
- These consumers are not counted in the monthly face-to-face contact requirement; however, face-to-face contact is required every 3 months and monthly calls are an allowed billable service.
- These consumers who are progressively non-compliant, have increased symptoms, increased resource needs, or increased risk due to poor natural supports should be reconsidered for traditional CSI or CST.

7. When Community Support - Individual supports an individual participating in the Children's LEVEL OF CARE program:
    - Services must be focused on planning for the individual's reintegration into the community;
    - Services or supports which are duplicative of treatment supports offered through the Children's LEVEL OF CARE placement may not be provided;
    - Services may be exempt from aforementioned monthly face-to-face contact requirements; however, there must be documented face-to-face contact with the consumer at least once every three (3) months, as well as monthly phone contacts (more frequent phone contacts may be billed if related to discharge planning).

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
    - Mental Health Professional (MHP)
    - Substance Abuse Manager (SAM)
2. Under the supervision of a Physician, an MHP, or a SAM, the following staff may provide Community Support:
    - Certified Peer Specialists
    - Paraprofessional staff
3. Community Support - It is recommended that individual providers maintain a minimum consumer-to-staff ratio of 30 consumers per staff member, but must not exceed a maximum ratio of 50 consumers per staff member. Individuals who receive only medication management are not counted in the staff ratio calculation.

C. Clinical Operations

1. Community Support - Individual services provided to children and youth must include coordination with family and significant others and with other systems of care such as the school system, juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
2. Community Support - Individual providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially

if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, if the consumer wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).

3. The organization must have policies that govern the provision of services in natural settings and can document that it respects individuals' and/or families' right to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. Each Community Support - Individual provider must have policies and procedures for the provision of individual-specific outreach services, including means by which these services and individuals are targeted for such efforts.
6. The organization must have a Community Support Organizational Plan that addresses the following:
    - description of the particular rehabilitation, recovery and case management models utilized, types of intervention practiced, and typical daily schedule for staff
    - description of the staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated
    - description of the hours of operations as related to access and availability to the individuals served and
    - description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery/Resiliency Plan

D. Service Accessibility

1. Agencies that provide Community Support Services must regularly provide individuals with contact information for appropriate crisis intervention services (i.e. the after hours crisis services telephone number).

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

1. Providers serving children enrolled in the TRIS/LOC program as part of community maintenance and/or transition should use the 261 sub-unit for MHMRIS Reporting. All other children should be identified in MHMRIS by the 361 sub-unit.
2. All other applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

COMMUNITY SUPPORT – TEAM

Definition of Service: Community Support Team is a recovery oriented, intensive, community-based rehabilitation and outreach service available 24 hours per day, 7 days per week, that provides treatment and restorative/recovery/resiliency focused interventions to assist individuals in gaining access to necessary services; in managing (including teaching skills to self-manage) their psychiatric and/or addictive illnesses, in developing optimal independent/age-appropriate community living skills, and in setting and attaining consumer (and family in the case of children) defined recovery/resiliency goals. Services are provided utilizing a team approach, and must be documented in the Individualized Recovery/Resiliency Plan (IRP). Based upon the goals and needs of the individual, services may include:

Assistance to the individual in the development of the Individualized Recovery/Resiliency Plan (IRP); Psychoeducational and instrumental support to individuals and their families; Crisis assessment, support and intervention; and Individualized interventions, which may include:

1) Identification, with the consumer, of strengths which may aid the individual in recovery, as well as barriers that impede the development of skills necessary for independent functioning in the community;
2) Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
3) Service and resource coordination to assist the individual in gaining access to necessary rehabilitative services, medical services, general entitlement benefits, or other services;
4) Family counseling/training for individuals and their families (as related to the person's IRP);
5) Individualized, restorative one-to-one therapeutic interventions to develop interpersonal/social, community coping and independent living/functional skills (including adaptation to home, school and work environments);
6) Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues;
7) Assistance in the acquisition of symptom monitoring and illness self-management skills (which may include medication monitoring and assistance in development of self-medication skills) in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living;
8) Assistance with financial management skill development;
9) Assistance with personal development or school/work performance;
10) Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psychoeducational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc); and

11) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

Community Support Teams may serve as a step down service for individuals transitioning from Assertive Community Treatment/Intensive Family Intervention services or other higher levels of care, or for those with psychiatric hospitalizations/repeated detoxification incidence in the past 18 months. The service is provided to individuals to decrease hospitalizations and crisis episodes and increase community tenure/independent functioning; increase time working, in school or with social contacts; and personal satisfaction and autonomy. Through supports based on identified, individualized needs, the individual will reside in independent or semi-independent living arrangements and be engaged in the recovery process.

Target Population	Adults experiencing: Serious Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Serious Mental Illness Co-Occurring Serious Mental Illness and Mental Retardation/DD Co-occurring Substance-Related Disorders and Mental Retardation/DD, Children and Adolescents experiencing: SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and SED Co-Occurring SED and Mental Retardation/DD Co-occurring Substance-Related Disorders and Mental Retardation/DD
Initial Authorization	480 units (unit = 15 minutes)
Re-Authorization	Continued Stay Review is required every 180 days.
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 360 – Community Support - Team — 08 – Outpatient
UAS: **Budget and Expense Categories**	Intensive Treatment Services Provider 151 – Adult Mental Health 251 – C&A Mental Health 751 – Adult Addictive Diseases 851 – C&A Addictive Diseases
Medicaid:	Mental Health Y3036 – Community Support Team Addictive Diseases Y3036 – Community Support Team

Admission Criteria	Individuals with moderate to severe symptoms, **and 4 or more of the following conditions:** • High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 2 or more admissions per year), or extended hospital stay (30 days within the past year), or psychiatric emergency services. • High use of detoxification services (e.g. 2 or more episodes per year) • History of inadequate follow-through with elements of a Recovery/Resiliency Plan related to risk factors, including lack of follow-through taking medications, following a crisis plan, or maintaining housing. • Medication resistant due to intolerable side effects or illness prohibits consistent self-management of medications. • Legal issues such as conditional release for nonviolent offense or history of failures to show up in court. • Homeless or at high risk of homelessness due to residential instability. • Child and/or family behavioral health issues have not shown improvement in traditional outpatient treatment and require coordinated clinical and supportive interventions; (what does this "or" mean here?- confusing. Are the bullets below still part of the potential 4 conditions that must be met?) • Because of behavioral health issues, the child has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent • Clinical evidence of suicidal gestures and/or ideation in past 3 months. • Ongoing inappropriate public behavior within the last 3 months. • Self-harm or threats of harm to others within the last year. • Evidence of significant complications such as cognitive impairment, behavioral problems, or medical conditions. • A lower service intensity has been tried or considered and found inappropriate at this time.
Continuing Stay Criteria	1. Same as above.

Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. No longer meets admission criteria; **or** 3. Goals of the Individualized Recovery/Resiliency Plan have been substantially met **or**; 4. Individual requests discharge and is not in imminent danger of harm to self or others; **or** 5. Transfer to another service/level of care is warranted by change in individual's condition; **or** 6. Individual requires services not available in this level of care.
Service Exclusions	Not offered in conjunction with Assertive Community Treatment, Community Support Individual, or Intensive Family Intervention.
Clinical Exclusions	1. Presence of any psychiatric condition requiring a more intensive level of care. 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. Community Support Teams offer a comprehensive set of psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team provides community support services that are interwoven with rehabilitative efforts.
2. Services and interventions are highly individualized and tailored to the needs and preferences of the individual, with the goal of maximizing independence and supporting recovery.
3. The Community Support Team must see each consumer, at a minimum, twice a month, with one encounter focusing on symptom assessment/management and management of medications. Individuals must also receive a telephone check-in call once a month.
4. At least 60% of services are provided face-to-face with consumers and 80% of all face-to-face services are delivered in non-clinic settings during the authorization period.
5. There must be bi-monthly staffings, attended by an MHP/SAM, which specifically discuss the status of each individual consumer enrolled in the service. Evidence of these staffings must be documented in each consumer's chart/record.

B. Staffing Requirements

1. Minimum staffing requirements for a Community Support Team include the following:
    - Fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be a Mental Health Professional or Substance Abuse Manager.
    - Fulltime equivalent (FTE) certified Peer Support Specialist. If the Community Support Team is specialized in its services to children and adolescents, then there must be an alternate FTE substituted in this position. The individual on the child and adolescent team can be a paraprofessional rather than a certified Peer Support Specialist.
    - Paraprofessionals who work under the supervision of either a Mental Health Professional or a Substance Abuse Manager and who work on the team in sufficient fulltime equivalents to meet the required consumer-to-staff ratio.
2. Community Support Teams must be comprised of a minimum of 3 and a maximum of 4 staff members meeting the requirements above (including the FTE MHP/SAM Team leader).
3. The Community Support Team maintains a recommended consumer-to-practitioner ratio of no more than 18 consumers per staff member. Staff-to-consumer ratio takes into consideration evening, weekend and holiday hours, needs of special populations, and geographical areas to be served.
4. Documentation must demonstrate that at least 2 team members are actively engaged in the support of each consumer served by the team. Effective July 1, 2006, one of these team members must be appropriately credentialed/trained to provide any professional counseling and treatment modalities/interventions needed by the consumer and must provide these modalities/interventions as clinically appropriate according to the needs of the consumer.

C. Clinical Operations

1. Community Support Team services provided to children and youth must include coordination with family and significant others and with other systems of care such as school system, juvenile justice system, and children's protective services when appropriate to treatment and educational needs.
2. Community Support Team providers must have the ability to deliver services in various environments, such as homes, schools, jails, homeless shelters, juvenile detention centers, or street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent

possible (e.g. if staff must meet with an individual during their work time, if the consumer wishes, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).

3. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in these settings.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. Each Community Support Team provider must have policies and procedures for the provision of community-based services, including means by which these services and individuals are targeted for such efforts. The organization also must have policies and procedures for protecting the safety of staff that engage in these activities.
6. The organization must have a Community Support Team Organizational Plan that describes:
    - Particular rehabilitation, recovery and case management models utilized, types of intervention practiced, and typical daily schedule for staff
    - Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated
    - Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)
    - Hours of operation, the staff assigned and types of services provided to consumers, families, and/or guardians
    - How the plan for services is modified or adjusted to meet the needs specified in every Individualized Recovery/Resiliency Plan.
7. For individuals with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.

D. Service Accessibility

1. This service must be available 24 hours a day, 7 days a week with emergency response coverage. The team must be able to rapidly respond to early signs of relapse and decompensation. An on-call CST staff member skilled in crisis intervention must provide coverage.
2. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

CONSUMER/FAMILY ASSISTANCE

Definition of Service: Individuals may need a range of goods and community support services to fully benefit from mental health and addictive disease services. This time-limited service consists of goods and services purchased/procured on behalf of the consumer (e.g. purchase of a time-limited behavioral aide or mentor, a one-time rental payment to prevent eviction/homelessness, a utility deposit to help an individual move into the community and/or their own housing, environmental modification to the individual's home to enhance safety and ability to continue living independently etc) that will help promote individual functional enhancement and/or support to the individual's responsible family member(s)/responsible caregiver(s)/legal guardian to the benefit of the individual and his/her behavioral health stability. The goods/services procured must provide a *direct and critical* benefit to the individualized needs of the consumer, in accordance with the IRP, and lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status, or prevent an imminent crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of caregiver/family/guardian's ability or resources needed to maintain the individual's living in the home, hospitalization/institutionalization, etc). The service is not intended to pay for/provide ongoing service programming through the provider agency.

Target Population	Children, Adolescents or Adults defined as Core Customers of Ongoing Services who are diagnosed with: Mental Illness/SED Substance Related Disorders Co-Occurring Mental Illness/SED and Substance Related Disorders Co-Occurring Mental Illness/SED/Substance Related Disorders and Mental Retardation/Developmental Disabilities
Initial Authorization	While the actual assistance should be very short-term in nature, this service can be authorized as part of a 180 day Recovery/Resiliency plan.
Re-Authorization	One within a single fiscal year.
Authorization Period	180 days
MHMRIS: Subunit & Modality	Subunit: 125 – Consumer & Family Assistance Modality: 08 – Outpatient

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UAS: **Budget and Expense Categories**	Consumer/Family Support Services Provider 137 – Adult Mental Health 237 – C&A Mental Health 737 – Adult Addictive Diseases 837 – C&A Addictive Diseases
Medicaid:	NONE
Admission Criteria	1. Individual must meet Core Customer criteria for Ongoing services, **and** 2. Individual or the individual's caregiver/responsible family members/legal guardian must be in need of a specific good or service that will directly improve functioning (e.g. directly lead to an enhancement of specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or achieve a more independent living status), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of caregiver's/family's/guardian's ability or resources needed to maintain the individual's living in the home, hospitalization/institutionalization etc), **and** 3. Individual, caregiver/responsible family members/legal guardian, or provider must exhaust all other possible resources for obtaining the needed goods/services—this service provides payment of last resort, **and** 4. Individual has not received this service for more than one other episode of need during the current fiscal year.
Continuing Stay Criteria	1. Individual must continue to meet Core Customer criteria for Ongoing services, **and** 2. Individual or the individual's caregiver/responsible family members/legal guardian must continue to be in need of the same specific good or service as when enrolled in Consumer/Family Assistance, that will directly improve functioning (e.g. directly lead to an increase in specific positive behaviors/skills/resources that will allow the individual to leave an institution and/or obtain more independent living), or prevent a crisis or out-of home placement (e.g. eviction, homelessness, loss of independent living, loss of caregiver's/family's/guardian's ability or resources needed to maintain the individual's living in the home, hospitalization/institutionalization etc), **and** 3. Individual, caregiver/ responsible family members/legal guardian, or provider must continue to lack any other possible resources for obtaining the needed goods/services.

Discharge Criteria	1. Individual no longer meets Core Customer criteria for Ongoing services, **or** 2. Individual or the individual's caregiver/responsible family members/legal guardian no longer continues to be in need of the good or service, **or** 3. Individual or the individual's caregiver/responsible family members/legal guardian has received the good in the allotted amount or service for the allotted timeframe as described below in "Additional Service Criteria" # 3, **or** 4. The individual or the individual's caregiver/responsible family members/legal guardian request discontinuance of the service.
Service Exclusions	1. Goods and services that are included as a part of other services the individual is enrolled in or could be enrolled in are excluded.
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. This service must not pay for the regular staffing of specific programs or services in the provider's agency.
2. Service may pay for a 1:1 mentor, behavioral aide etc for an individual consumer, within the following limits:
   a. Other means are not available to pay for the mentor, behavioral aide etc., such as state funding, Medicaid, self-pay or private insurance.
   b. The mentor, behavioral aide etc cannot be used to supplement the staffing of any program or service in the provider agency.
   c. The mentor, behavioral aide etc cannot be used as a 1:1 staff for the consumer during the times the consumer is attending other programming/services offered by the provider agency.

C. Clinical Operations

1. This service must not pay for transportation to MH/DD/AD services.
2. This service must not pay for the operating, programmatic, or administrative expenses of any other program or service offered by the provider agency.
3. Individual cannot receive this service for more than two episodes of need per fiscal year.
4. Services obtained (e.g. a behavioral aide/mentor etc) are intended to be of short duration and must be provided through this service for no longer than 3 months, or until the direct consumer benefit is realized, whichever occurs sooner.

5. Each type of necessary good obtained through this service is intended to be of short duration and must be purchased for no longer/in no greater amount than is reasonably necessary to avoid/resolve the immediate crisis or achieve the targeted increase in functioning.

   Some items have specific limits that cannot be surpassed during a single episode of need. The least duration and/or amount necessary of such items should be provided. Up to:

   - one month's rental/mortgage assistance;
   - one month's assistance with utilities and/or other critical bills;
   - one housing deposit;
   - one month's supply of groceries (for the individual);
   - one month of medications;
   - one assistive device (unless a particular device is required in multiple according to commonly understood definition/practice such as a hearing aide for each ear, a one month supply of diabetic supplies etc);
   - one to two weeks worth of clothing.

   Similar guidelines should be used with other items not on this list.
6. The maximum yearly monetary limit for this service is $2000 per individual per fiscal year. Individuals leaving an institution after a stay of at least 60 days who have had their benefits suspended or who do not yet have income or other benefits established may need greater assistance than the allowances indicated above for rent, bills, groceries and other items/services. For such individuals, multiple months of rent, bills, groceries, services etc may be purchased, at a maximum yearly monetary limit of $5000 per individual per fiscal year.
7. The individual's caregiver/responsible family members/legal guardian is/are eligible only if the individual is residing in the same residence, or if funds would be used to prepare the home and caregiver/responsible family members/legal guardian for the return of the individual to the home from an alternative living arrangement. Eligibility for the Consumer/Family Assistance service does not equate to an entitlement to the service. Prioritizing eligible individuals and/or their caregivers/responsible family members/legal guardians to receive services is the responsibility of the service provider. A standard protocol must be utilized by the service provider to assess and approve the individual and/or the individual's caregiver's/responsible family members'/legal guardian's needs in regard to 1) the criticalness of the need(s) in terms of the individual's functioning and ability to return to/remain in the community, and 2) the individual's and/or caregiver's/responsible family's/legal guardian's or provider's ability to obtain the needed goods or services through other viable means.

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service.

F. Reporting Requirements

1. The agency must submit a monthly report to the DMHDDAD in a specified format.
2. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Documentation that authorized goods/services are not available through other viable means must be made in the individual's chart.
2. Details regarding the goods/services procured and resulting benefit to the individual consumer must be documented in the individual's chart.

CRISIS INTERVENTION

Definition of Service: Services directed toward the support of an individual who is experiencing an abrupt and substantial change in behavior which is usually associated with a precipitating situation and which is in the direction of severe impairment of functioning or a marked increase in personal distress. Crisis Intervention is designed to prevent out of home placement or hospitalization. Often, a crisis exists at such time as an individual consumer and/or his or her family/responsible caregiver(s) decide to seek help and/or the individual, – family/responsible caregiver(s), or practitioner identifies the situation as a crisis. Crisis services are time-limited and present-focused in order to address the immediate crisis and develop appropriate links to alternate services. Services may involve the individual consumer and the individual's family/responsible caregiver(s) and/or significant other, as well as other service providers. Services are available 24-hours per day, 7 days per week, and may be offered by telephone and/or face-to-face in any setting (e.g. home, school, jail, hospital, clinic etc).

The current safety plan (children)/ behavioral health care advanced directive (adults), if existing, should be utilized to help manage the crisis. Interventions provided should honor and be respectful of the individual's wishes/choices by following the plan/advanced directive as closely as possible in line with appropriate clinical judgment. Plans/advanced directives developed during the Diagnostic Assessment/IRP process should be reviewed and updated (or developed if the individual is a new consumer) as part of this service to help prevent or manage future crisis situations.

Some examples of interventions that may be used to de-escalate a crisis situation could include: a situational assessment; active listening and empathic responses to help relieve emotional distress;
effective verbal and behavioral responses to warning signs of crisis related behavior; assistance to, and involvement/participation of the individual (to the extent he or she is capable) in active problem solving planning and interventions; facilitation of access to a myriad of crisis stabilization and other services deemed necessary to effectively manage the crisis; mobilization of natural support systems; and other crisis interventions as appropriate to the individual and issues to be addressed.

Target Population	Individuals with Mental Health issues and/or Substance Related Disorders Individuals experiencing a severe situational crisis
Initial Authorization	16 units (unit = 15 minutes)
Re-Authorization	Any use beyond 16 units will not be denied but will trigger an immediate retrospective review.

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Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 304 – Crisis Intervention — 08 – Outpatient
UAS: **Budget and Expense Categories**	Crisis Services Provider 133 – Adult Mental Health 233 – C&A Mental Health 733 – Adult Addictive Diseases 833 – C&A Addictive Diseases
Medicaid:	Mental Health Y3013 – In-Clinic Crisis Intervention Y3027 – Out-of-Clinic Crisis Intervention Addictive Diseases Y3013 – In-Clinic Crisis Intervention Y3027 – Out-of-Clinic Crisis Intervention
Admission Criteria	1. Treatment at a lower intensity has been attempted or given serious consideration; **and #2 and/or #3 are met:** 2. Individual has a known or suspected mental health diagnosis or Substance Related Disorder; **or** 3. Individual is at risk of harm to self, others and/or property. Risk may range from mild to imminent; **and one or both of the following:** 4. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; **or** 5. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual and moves him/her to the appropriate level of care.
Discharge Criteria	1. Individual no longer meets continued stay guidelines; and 2. Crisis situation is resolved and an adequate continuing care plan has been established.
Service Exclusions	None
Clinical Exclusions	1. The individuals' presenting situation is not dangerous to self or others. 2. Severity of clinical issues precludes provision of services at this level of care.

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. Service must be furnished by a Mental Health Professional (MHP), Substance Abuse Professional (SAP), Substance Abuse Manager (SAM), or staff under the supervision of an MHP or SAM.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. In any review of clinical appropriateness of this service, the mix of services offered to the individual is important. The use of crisis units will be looked at by the External Review Organization in combination with other supporting services. For example, if an individual presents in crisis and the crisis is alleviated within an hour but ongoing support continues, it is expected that 4 units of crisis will be billed and then some supporting service such as individual counseling will be utilized to support the individual during that interval of service.
2. This service must be billed as either In-Clinic or Out-of-Clinic Crisis Management/ Intervention for Medicaid recipients.

F. Reporting Requirements

1. Enrollments to MHMRIS requires that a consumer be enrolled and released each time the consumer receives this service and may not remain open as an active enrollment.
2. All other applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

CRISIS STABILIZATION PROGRAM

Definition of Service: This is a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization and substance detoxification services on a short-term basis. Specific services may include:

1) Psychiatric medical assessment;
2) Crisis assessment, support and intervention;
3) Medically Monitored Residential Substance Detoxification (at ASAM Level III.7-D).
4) Medication administration, management and monitoring;
5) Brief individual, group and/or family counseling; and
6) Linkage to other services as needed.

Services must be provided in a facility designated and certified by the Division of MHDDAD as an emergency receiving and evaluation facility

Target Population	Adults experiencing: Severe situational crisis Severe Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation, Children and Adolescents experiencing: Severe situational crisis SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-Occurring Substance-Related Disorders and Mental Retardation
Initial Authorization	20 days
Re-Authorization	
Authorization Period	20 days
MHMRIS: Subunit & Modality	Subunit / Modality 500 – Crisis Stabilization / 04 – Residential 599 – Transitional Bed / 04 – Residential

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UAS: **Budget and Expense Categories**	Crisis Services Provider 134 – Adult Mental Health 234 – C&A Mental Health 734 – Adult Addictive Diseases 834 – C&A Addictive Diseases
Medicaid:	Mental Health Y3028 – Crisis Residential Services Addictive Diseases Y3028 – Crisis Residential Services
Admission Criteria	1. Treatment at a lower level of care has been attempted or given serious consideration; **and #2 and/or #3 are met**: 2. Individual has a known or suspected illness/disorder in keeping with target populations listed above; **or** 3. Individual is experiencing a severe situational crisis which has significantly compromised safety and/or functioning; **and one or more of the following**: 4. Individual presents a substantial risk of harm or risk to self, others, and/or property or is so unable to care for his or her own physical health and safety as to create a life-endangering crisis. Risk may range from mild to imminent; **or** 5. Individual has insufficient or severely limited resources or skills necessary to cope with the immediate crisis; **or** 6. Individual demonstrates lack of judgment and/or impulse control and/or cognitive/perceptual abilities to manage the crisis; **or** 7. For detoxification services, individual meets admission criteria for Medically Monitored Residential Detoxification.
Continuing Stay Criteria	This service may be utilized at various points in the individual's course of treatment and recovery, however, each intervention is intended to be a discrete time-limited service that stabilizes the individual.
Discharge Criteria	1. Individual no longer meets admission guidelines requirements; **or** 2. Crisis situation is resolved and an adequate continuing care plan has been established; **or** 3. Individual does not stabilize within the evaluation period and must be transferred to a higher intensity service.
Service Exclusions	This is a comprehensive service intervention that is not to be provided with any other service(s), except for the following: • Methadone Administration as part of Medical Administration, Diagnosis/Functional Assessment, • Community Support- Individual or Community Support- Team as part of a transition to these less intensive services.

Clinical Exclusions	1. Individual is not in crisis. 2. Individual does not present a risk of harm to self or others or is able to care for his or her own physical health and safety. 3. Severity of clinical issues precludes provision of services at this level of intensity.

Additional Service Criteria:

A. Required Components

1. Crisis Stabilization Programs (CSP) providing medically monitored short-term residential psychiatric stabilization and detoxification services, shall be designated by the Department as both an emergency receiving facility and an evaluation facility and must be surveyed and certified by the Division of MHDDAD.
2. In addition to all service qualifications specified in this document, providers of this service must adhere to and be certified under the *Provider Manual for Community Mental Health, Developmental Disability and Addictive Disorders "*Core Requirements for All Providers" and DMHDDAD "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
3. Individual referred to a CSP must be evaluated by a physician within 24 hours of the referral.
4. Maximum stay in a crisis bed is 10 days (excluding Saturdays, Sundays and holidays) for adults (an adult occupying a transitional bed may remain in the CSP for an unlimited number of additional days if the date of transfer and length of stay in the transitional bed is documented).
5. Maximum stay in a crisis bed is 14 days (excluding Saturdays, Sundays and holidays) for children and adolescents (a child/adolescent occupying a transitional bed may remain in the CSP for additional calendar days (not to exceed total of 29 calendar days in the CSP) if the date of transfer and length of stay in the transitional bed is documented).
6. Individuals occupying transitional beds must receive services from outside the CSP (i.e. community-based services) on a daily basis.
7. Services must be provided in a facility designated as an emergency receiving and evaluation facility that is not also an inpatient hospital, a freestanding Institute for Mental Disease (IMD), or a licensed substance abuse detoxification facility.
8. All services provided within the CPS must be delivered under the direction of a physician. A physician must conduct an assessment of new admissions, address issues of care, and write orders as required.

B. Staffing Requirements

1. Crisis Stabilization Program (CSP) Services must be provided by a physician or a staff member under the supervision of a physician, practicing within the scope of State law.
2. A CSP must employ a fulltime Nursing Administrator who is a Registered Nurse.

3. A CSP must have a Registered Nurse present at the facility at all times.
4. Staff-to-client ratios must be established based on the stabilization needs of clients being served and in accordance with the "Core Requirements for Crisis Stabilization Programs Operated by Community Service Boards."
5. Functions performed by Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Registered Nurses, and Licensed Practical Nurses must be performed within the scope of practice allowed by State law and Professional Practice Acts.

C. Clinical Operations

1. CPS must have documented operating agreements and referral mechanisms for psychiatric disorders, addictive disorders, and physical healthcare needs that are beyond the scope of the CPS and that require inpatient treatment. Operating agreements must delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility. These agreements must specifically address the criteria and procedures for transferring an individual to a designated treatment facility when the CPS is unable to stabilize the individual.
2. CPS must follow the seclusion and restraint procedures included in the Division's "Core Requirements for Crisis Stabilization Programs operated by Community Service Boards."
3. For individuals with co-occurring diagnoses including mental retardation/developmental disabilities, this service must target the symptoms, manifestations, and skills-development related to the identified behavioral health issue.
4. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSP, and are expected to engage in community-based services daily while in a transitional bed.

D. Service Access

E. Additional Medicaid Requirements

1. Crisis Stabilization Programs are billed as Crisis Residential Services for Medicaid recipients.
2. For those CSPs that bill Medicaid, Crisis Residential Services are limited to 16 beds.

F. Reporting Requirements

1. Providers must designate either CSP bed use or transitional bed use in MHMRIS submissions.
2. All other applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. For individuals transferred to transitional beds, the date of transfer must be documented in a progress note and filed in the individual's chart.
2. Daily engagement in community-based services must also be documented in progress notes for those occupying transitional beds.

DIAGNOSTIC ASSESSMENT AND INDIVIDUALIZED RECOVERY/RESILIENCY PLANNING

Definition of Service: Individuals access this service when it has been determined through an initial screening that the person has mental health or addictive disease needs. The initial Diagnostic Assessment and resulting Individualized Recovery/Resiliency Plan are required within the first 45 days of service, with ongoing Diagnostic Assessments and plans completed as demanded by individual consumer need and/or by service policy. The Diagnostic Assessment and Individualized Recovery/Resiliency Planning process consists of a face-to-face comprehensive clinical assessment with the individual, which must include the individual's perspective, and may also include family and/or significant others as well as collateral agencies/treatment providers/relevant individuals.

The purpose of the process is to perform a formalized assessment in order to determine the individual's problems, strengths, needs, abilities and preferences, to develop a social (extent of natural supports and community integration) and medical history, to determine functional level and degree of ability versus disability, and to develop or review collateral assessment information. The information gathered should support the determination of a differential diagnosis and assist in screening for/ruling-out potential co-occurring disorders.

Information from the diagnostic assessment should ultimately be used to develop, together with the individual, an Individualized Recovery/Resiliency Plan that supports recovery/resilience and that is based on goals identified by the individual (with parent(s)/responsible caregiver(s) involvement if consumer is a child). As indicated, medical, nursing, peer, vocational, nutritional, etc staff should inform the assessment and resulting IRP.

The cornerstone component of the adult Diagnostic Assessment and resulting Individualized Recovery Plan (IRP) involves a discussion with the adult individual regarding what recovery means to him or her personally (e.g. getting/keeping a job, having more friends, improvement of behavioral health symptoms etc), and the development of goals (i.e. outcomes) and objectives that are defined by, and meaningful to the individual based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized behavioral health care advanced directive should also be developed, with the individual guiding these processes through the free expression of his or her wishes and through his or her assessment of the components developed for the advanced directive as being realistic for him or her.

The cornerstone component of the child and adolescent Diagnostic Assessment and resulting Individualized Resiliency Plan (IRP) involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g. the child having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc), and the development of goals (i.e. outcomes) and

objectives that are defined by and meaningful to the child/adolescent based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual child and parent(s)/responsible caregiver(s) guiding these process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them.

The entire process should involve the individual as a full partner and should focus on service and recovery/resiliency goals/outcomes as identified by the individual.

Target Population	A known or suspected mental health diagnosis and/or Substance-Related Disorder.
Initial Authorization	16 units (unit = 15 minutes)
Re-Authorization	16 units (unit = 15 minutes)
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 302 – Diagnostic Assessment — 08 – Outpatient
UAS: **Budget and Expense Categories**	Core Services Provider 120 – Adult Mental Health 220 – C&A Mental Health 720 – C&A Addictive Diseases 820 – C&A Addictive Diseases Crisis Services Provider 132 – Adult Mental Health 232 – C&A Mental Health 732 – Adult Addictive Diseases 832 – C&A Addictive Diseases Residential Services Provider 141 – Adult Mental Health 241 – C&A Mental Health 741 – Adult Addictive Diseases 841 – C&A Addictive Diseases Intensive Treatment Services Provider 150 – Adult Mental Health 250 – C&A Mental Health 750 – Adult Addictive Diseases 850 – C&A Addictive Diseases Psychosocial Rehabilitation Provider 154 – Adult Mental Health

	Intensive Day Treatment Services Provider 158 – Adult Mental Health C&A Day Services Provider 254 – C&A Mental Health 854 – C&A Addictive Diseases C&A Activity Therapy Services 261 – C&A Mental Health 861 – C&A Addictive Diseases Adult Substance Abuse Day Treatment 754 – Adult Addictive Diseases Opioid Maintenance Treatment Provider 762 – Adult Addictive Diseases Substance Abuse Detox Services Provider 764 – Adult Addictive Diseases 864 – C&A Addictive Diseases
Medicaid:	Mental Health Y3000 – Diagnostic Assessment Addictive Diseases Y3000 – Diagnostic Assessment
Admission Criteria	1. A known or suspected mental illness or substance-related disorder; **and** 2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; **and** 3. Individual meets Core Customer eligibility.
Continuing Stay Criteria	Individual's situation/functioning has changed in such a way that previous assessments are outdated.
Discharge Criteria	Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.
Service Exclusions	None
Clinical Exclusions	None

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. These services are performed by a Mental Health Professional, Substance Abuse Professional, Substance Abuse Manager, or Certified Addiction Counselor II.

C. Clinical Operations

1. The individual consumer (and caregiver/responsible family members etc as appropriate) should actively participate in the assessment and planning processes.
2. The Individualized Recovery/Resiliency Plan should be directed by the individual's/family's personal recovery/resiliency goals as defined by them.
3. Advanced Directive planning (adults)/Safety planning (children and adolescents) should be directed by the individual/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the individual/family and that the individual/family is therefore not likely to follow through with.

D. Service Access

E. Additional Medicaid Requirements

1. These services are performed by a Mental Health Professional, Substance Abuse Professional, Substance Abuse Manager, or Certified Addiction Counselor II.
2. Nutritional assessments indicated by an individual's confounding health issues may be billed under this code. No more than 8 units specific to nutritional assessments can be billed for an individual within a year. This specific assessment must be provided by a Registered Nurse or by a Registered Clinical Dietician.

F. Reporting Requirements

1. For the purposes of reporting to MHMIRS, consumers should be enrolled and released upon completion of the assessment. Consumer enrollments are not to remain open beyond the time that it takes to complete this service.
2. All other applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. The initial authorization/IRP and each subsequent authorization/IRP must be completed within the time-period specified by DMHDDAD.
2. In addition to the authorization and Individualized Recovery/Resiliency Plan produced through this service, documentation of clinical assessment findings from this service should also be completed and placed in the individual's chart as a Comprehensive Assessment.

FAMILY TRAINING/COUNSELING

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified family populations, diagnoses and service needs, provided by a qualified clinician or practitioner (a licensed therapist may conduct both counseling and training types of services/activities). Services are directed toward achievement of specific goals defined by the individual consumer (and by the parent(s)/responsible caregiver(s) in the case of children) and specified in the Individualized Recovery/Resiliency Plan (note: although interventions may involve the family, the focus or primary beneficiary of intervention must always be the individual consumer). Family training/counseling provides systematic interactions between the identified individual consumer, staff and the individual's family members directed toward the restoration, development, enhancement or maintenance of functioning of the identified consumer/family unit. This may include support of the family, as well as training and specific therapeutic interventions/activities to enhance family roles, relationships, communication and functioning that promote the recovery and resiliency of the individual/family unit. Specific goals/issues to be addressed though these services may include the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed/helping a family member to take medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills;
6) family roles and relationships;
7) daily living skills;
8) resource access and management skills; and
9) the family's understanding of mental illness and substance related disorders, the steps necessary to facilitate recovery/resiliency, and methods of intervention, interaction and mutual support the family can use to assist their family member.

Some examples of best/evidence-based practice are Brief Strategic Family Therapy, Family Education and Support, and MDFT.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Initial Authorization	Total outpatient bundle = 200 units (unit=15 minutes)
Re-Authorization	200 units
Authorization Period	180 days
MHMRIS: Subunit & Modality	Subunit: 203 – Family Training/Counseling; Modality: 08 – Outpatient

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

UAS: Budget and Expense Categories	Core Services Provider 130 – Adult Mental Health 230 – C&A Mental Health 730 – Adult Addictive Diseases 830 – C&A Addictive Diseases
Medicaid:	Mental Health Y3014 – Family Training/Counseling Addictive Diseases Y3014 – Family Training/Counseling
Admission Criteria	1. Individual must have a mental illness and/or substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. Individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. Individual's assessment indicates needs which may be supported by a therapeutic intervention shown to be successful with identified family populations and individual's diagnoses.
Continuing Stay Criteria	1. Individual continues to meet Admission Criteria as articulated above; **and** 2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but all treatment/support goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery/Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and individual is in imminent danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in individual's condition; **or** 5. Individual requires more intensive services.
Service Exclusions	ACT, Crisis Residential, and Intensive Family Intervention
Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as

	Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual/family/caregiver.
2. Couple's counseling is included under this service code as long as the counseling is directed toward the identified consumer and his/her goal attainment as identified in the Individualized Recovery/Resiliency Plan.
3. The Individualized Recovery/Resiliency Plan for the individual includes goals and objectives specific to the family for whom the service is being provided.

B. Staffing Requirements

1. Family training is provided by or under the supervision of a Mental Health Professional or a Substance Abuse Manager. Family counseling must be provided by a Mental Health Professional or a Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services.
2. Training and Counseling should be differentiated by practice and practitioner. When the aforementioned services are addressed through didactic training, structured practice, coaching techniques, etc., a practitioner may include those with licenses to provide counseling (O.C.G.A. Practice Acts) and other paraprofessionals (including Certified Peer Specialists). Only a licensed clinician may perform family counseling when the intervention includes techniques involving the principles, methods and procedures of counseling that assist the family in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices. Modes of best practice delivery may include (as clinically appropriate) Multidimensional Family Therapy, Behavioral Family Therapy, Functional Family Therapy, and others as appropriate the family and issues to be addressed.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

GROUP TRAINING/COUNSELING

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided in a group format by a qualified clinician or practitioner (a licensed therapist may conduct both counseling and training types of services/activities). Services are directed toward achievement of specific goals defined by the individual consumer (and by the parent(s)/responsible caregiver(s) in the case of children) and specified in the Individualized Recovery/Resiliency Plan. Services may address goals/issues such as promoting recovery/resiliency, and the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills;
6) daily living skills;
7) resource management skills;
8) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs; and
9) skills necessary to access community resources and support systems.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Initial Authorization	Total outpatient bundle = 200 units (unit=15 minutes)
Re-Authorization	200 units
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 202 – Group Training/Counseling — 08 – Outpatient
UAS: **Budget and Expense Categories**	Core Services Provider 129 – Adult Mental Health 229 – C&A Mental Health 729 – Adult Addictive Diseases 829 – C&A Addictive Diseases
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Mental Health Y3015 – Group Training/Counseling Addictive Diseases Y3015 – Group Training/Counseling

Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. The individual's recovery/resiliency goal which is to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery/Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; **or** 4. Transfer to another service/level of care is warranted by change in individual's condition; **or** 5. Individual requires more intensive services.
Service Exclusions	Crisis Residential See also below, Item A.2.
Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual/family/caregiver.
2. Extended groups are not allowed under this service code. Any services in excess of 2 hours in a given day may be subject to scrutiny by the external review organization.
3. Group outpatient services should very rarely be offered in addition to day services. Any exceptions must be clinically justified in the record and may be subject to scrutiny by the external review organization. Exceptions in offering group outpatient services external to day services include such sensitive and targeted clinical issue groups as incest survivor groups, perpetrator groups, and sexual abuse survivors groups. When an exception is clinically justified, services must not duplicate day support/treatment activities.
4. When billed concurrently with ACT/IFI services, this service must focus on group counseling rather than training, and counseling must be curriculum based. Groups for ACT/IFI service recipients cannot include non-ACT/IFI service recipients.

B. Staffing Requirements

1. Training is provided by or under the supervision of a Mental Health Professional or a Substance Abuse Manager. Group counseling must be provided by a Mental Health Professional or a Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to Perform Counseling Services. Maximum face-to-face ratio cannot be more than 10 consumers to 1 direct service staff based on average group attendance.
2. Training and Counseling should be differentiated by practice and practitioner. When the aforementioned services are addressed through didactic training, structured practice, coaching techniques, etc., a practitioner may include those with licenses to provide counseling (O.C.G.A. Practice Acts) and other paraprofessionals (including Certified Peer Specialists). Only a licensed clinician may perform group counseling when the intervention includes techniques involving the principles, methods and procedures of counseling that assist the group in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns.
3. Practitioners providing this service are expected to maintain knowledge and skills regarding group practice such as selecting appropriate participants for a particular group, working with the group to establish necessary group norms and goals, and understanding and managing group dynamics and processes.

C. Clinical Operations

1. Community-based group skills training is allowable and clinically valuable for some consumers; therefore, this option should be explored to the benefit of the consumer. In this event, staff must be able to assess and address the individual needs and progress of each consumer consistently throughout the intervention/activity (e.g. in an example of teaching 2-3 consumers to access public transportation in the community, group training may be given to help each consumer individually to understand the bus schedule in a way that makes sense to them, to address questions/concerns each may

have about how to use the bus, perhaps to spend time riding the bus with the consumers and assisting each to understand and become comfortable with riding the bus in accordance with *individual* goals, etc).

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

INDIVIDUAL COUNSELING

Definition of Service: A therapeutic intervention or counseling service shown to be successful with identified populations, diagnoses and service needs, provided by a qualified clinician. Techniques employed involve the principles, methods and procedures of counseling that assist the person in identifying and resolving personal, social, vocational, intrapersonal and interpersonal concerns. Services are directed toward achievement of specific goals defined by the individual consumer (and by the parent(s)/responsible caregiver(s) in the case of children) and specified in the Individualized Recovery/Resiliency Plan. These services address goals/issues such as promoting recovery/resiliency, and the restoration, development, enhancement or maintenance of:

1) illness and medication self-management knowledge and skills (e.g. symptom management, behavioral management, relapse prevention skills, knowledge of medications and side effects, and motivational/skill development in taking medication as prescribed);
2) problem solving and cognitive skills;
3) healthy coping mechanisms;
4) adaptive behaviors and skills;
5) interpersonal skills; and
6) knowledge regarding mental illness, substance related disorders and other relevant topics that assist in meeting the individual's or the support system's needs.

Best/evidence based practice modalities may include (as clinically appropriate): Motivational Interviewing/Enhancement, Cognitive Behavioral Therapy, Behavioral Modification, Behavioral Management, Rational Behavioral Therapy, Dialectical Behavioral Therapy, Interactive Play Therapy, and others as appropriate to the individual and clinical issues to be addressed.

Target Population	Individuals with Mental Illness and/or Substance-Related Disorders
Initial Authorization	Total outpatient bundle = 200 units (unit=15 minutes)
Re-Authorization	200 units
Authorization Period	180 days
MHMRIS: Subunit & Modality	Subunit: 201 – Individual Counseling; Modality: 08 – Outpatient

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

UAS: **Budget and Expense Categories**	Core Services Provider 128 – Adult Mental Health 228 – C&A Mental Health 728 – Adult Addictive Diseases 828 – C&A Addictive Diseases
Medicaid:	Mental Health Y3016 – Individual Counseling Addictive Diseases Y3016 – Individual Counseling
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places others in danger) or distressing (causes mental anguish or suffering); **and** 2. The individual's level of functioning does not preclude the provision of services in an outpatient milieu; **and** 3. The individual's recovery/resiliency goal which is to be addressed by this service must be conducive to response by a group milieu.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and.** 2. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. Adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery/Resiliency Plan have been substantially met.; **or** 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; **or** 4. Transfer to another service is warranted by change in individual's condition; **or** 5. Individual requires a service approach which supports less or more intensive need.
Service Exclusions	ACT, Crisis Residential, and Intensive Family Intervention

Clinical Exclusions	1. Severity of behavioral health impairment precludes provision of services. 2. Cognitive impairment precludes provision of services in this level of care. 3. There is a lack of social support systems such that a more intensive level of service is needed. 4. There is no outlook for improvement with this particular service 5. This service is not intended to supplant other services such as Personal and Family Support or any day services where the individual may more appropriately receive these services with staff in various community settings. 6. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The treatment orientation, modality and goals must be specified and agreed upon by the individual/family/caregiver.

B. Staffing Requirements

1. Individual Counseling must be provided by a Mental Health Professional or Substance Abuse Professional who is licensed/credentialed by the State of Georgia under the Practice Acts to perform counseling services.
2. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based counseling practices.

C. Clinical operations

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

MEDICATION ADMINISTRATION

Definition of Service: The giving or administration of an oral medication or injection. Medication administration requires a physician's order, and medication must be administered by licensed medical personnel under the supervision of a physician. The service must include:

1. An assessment, by the licensed medical personnel administering the medication, of the individual's physical, psychological and behavioral status in order to make a recommendation regarding whether to continue the medication and/or its means of administration, and whether to refer the individual to the physician for a medication review.
2. Education to the individual and/or family/responsible caregiver(s), by appropriate licensed medical personnel, on the proper administration and monitoring of prescribed medication in accordance with the individual's plan of care.

This service may also include the administration of medication for opioid/methadone maintenance in accordance with state law (see also Opioid Maintenance Code).

Target Population	Individuals with Mental Illness/SED Individuals with Substance Related Disorders Individuals with Co-occurring Mental Illness/SED and Substance Related Disorders Individuals with Co-occurring Mental Illness/SED and MR/DD Individuals with Co-occurring Substance Related Disorders and MR/DD	
Initial Authorization	15 units for Adult MH, SA, unit = 1 contact (billing for only one contact per day is allowed)	30 units for C&A SED, unit = 1 contact (billing for only one contact per day is allowed)
Re-Authorization	15 units for Adult MH, SA, unit = 1 contact (billing for only one contact per day is allowed)	30 units for C&A SED, unit = 1 contact billing for only one contact per day is allowed)
Authorization Period	180 days	
MHMRIS: Subunit & Modality	Subunit 307 – Medication Administration	Modality 08 – Outpatient
UAS: Budget and Expense Categories	Core Services Provider 124 – Adult Mental Health 224 – C&A Mental Health 724 – Adult Addictive Diseases 824 – C&A Addictive Diseases	

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

Medicaid:	Mental Health Y3012 – Medication Administration Addictive Diseases Y3012 – Medication Administration
Admission Criteria	1. Individual must have a primary mental illness/substance-related disorder diagnosis that is at least destabilizing (markedly interferes with the ability to carry out activities of daily living or places self/others in danger) or distressing (causes mental anguish or suffering); **and** 2. Individual is unable to self-administer prescribed medication because: a. Although individual is willing to take the prescribed medication, it is in an injectable form and must be administered by licensed medical personnel; **or** b. Although individual is willing to take the prescribed medication, it is a Class A controlled substance (e.g. Methadone) which must be stored and dispensed by medical personnel in accordance with state law; **or** c. Due to severity of the mental illness/substance related disorder, individual is unwilling/unable to administer needed medication; **and** as evidenced by the individual's history, the individual would likely be in danger of harm to self, others or property without the medication
Continuing Stay Criteria	1. Individual continues to meet admission criteria. 2. If methadone is indicated, individual must meet criteria established by the Georgia Regulatory body for methadone administration programs (Department of Human Resources-DMHDDAD) and the Food and Drug Administration's guidelines for this service.
Discharge Criteria	1. Individual no longer needs medication; or 2. Individual is able to self-administer medication; or 3. Must meet criteria established by the Georgia Regulatory body for methadone administration programs (Department of Human Resources- DMHDDAD) and the Food and Drug Administration's guidelines for this service; and 4. Adequate continuing care plan has been established.
Service Exclusions	1. Does not include medication given as a part of Ambulatory Detoxification. Medication administered as part of Ambulatory Detoxification is billed as "Ambulatory Detoxification." 2. Must not be billed in the same day as Nursing Assessment or Crisis Residential. 3. Must not be billed while enrolled in CSP or ACT except if this Medication Administration service is utilized only for the

	administration of methadone (for Medicaid recipients). 4. For Medicaid recipients who need opioid maintenance, this service should be utilized in place of Opioid Maintenance.

Additional Service Criteria:

A. Required Components

1. There must be a physician's order for the medication and for the administration of the medication. The order must be in the individual's chart. Telephone orders are acceptable provided they are cosigned by the physician in accordance with DMHDDAD standards.
2. Documentation must support that the individual is being trained in the risk and benefits of the medications being administered and that symptoms are being monitored by the staff member administering the medication.
3. Documentation must support that the individual is being trained in the principle of self-administration of medication or that the individual is physically or mentally unable to self-administer. This documentation may be subject to scrutiny by the External Review Organization in reauthorizing services in this category.
4. This service does not include the supervision of self-administration of medication.
5. An agency that administers methadone must meet criteria established by the Georgia regulatory body for methadone administration programs (Department of Human Resources –DMHDDAD) and the Food and Drug Administrations guidelines for this service.

B. Staffing Requirements

1. Medication must be administered by licensed medical personnel under the supervision of a physician.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients who need opioid maintenance, this service should be utilized in place of Opioid Maintenance.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

NURSING ASSESSMENT AND HEALTH SERVICES

Definition of Service: This service requires face-to-face contact with the individual to monitor, evaluate, assess, and/or carry out a physician's orders regarding the physical and/or psychological problems of the individual. It includes:

1) Providing nursing assessments to observe, monitor and care for the physical, nutritional and psychological issues, problems or crises manifested in the course of an individual's treatment;
2) Assessing and monitoring individual's response to medication(s) to determine the need to continue medication and/or to determine the need to refer the individual to a physician for a medication review;
3) Assessing and monitoring an individual's medical and other health issues that are either directly related to the mental health or substance related disorder, or to the treatment of the disorder (e.g. diabetes, cardiac and/or blood pressure issues, substance withdrawal symptoms, weight gain and fluid retention, seizures, etc);
4) Consulting with the individual's family and significant other(s) about medical, nutritional and other health issues related to the individual's mental health or substance related issues;
5) Educating the individual and family/responsible caregiver(s) on medications and potential medication side effects (especially those which may adversely affect health such as weight gain or loss, blood pressure changes, cardiac abnormalities, development of diabetes or seizures, etc); and
6) Training for self-administration of medication.

Target Population	Individuals with Mental Health issues/Serious Mental Illness/SED and/or Substance Related Disorders Individuals with Mental Health issues/Serious Mental Illness/SED and MR/DD Individuals with Substance Related Disorders and MR/DD
Initial Authorization	Total outpatient bundle = 200 units (unit = 15 minutes)
Re-Authorization	200 units
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit: 306 – Nursing Assessment and Services Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	Core Services Provider 123 – Adult Mental Health 223 – C&A Mental Health 723 – Adult Addictive Diseases 823 – C&A Addictive Diseases

Medicaid:	Mental Health Y3006 – Nursing Assessment and Health Services Addictive Diseases Y3006 – Nursing Assessment and Health Services
Admission Criteria	1. Individual presents symptoms that are likely to respond to medical/nursing interventions; **or** 2. Individual has been prescribed medications as a part of the treatment array or has a confounding medical condition.
Continuing Stay Criteria	1. Individual continues to demonstrate symptoms that are likely to respond to or are responding to medical interventions; **or** 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; **or** 3. Individual demonstrates progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual no longer demonstrates symptoms that are likely to respond to or are responding to medical/nursing interventions; **or** 3. Goals of the Individualized Recovery/Resiliency Plan have been substantially met; **or** 4. Individual/family requests discharge and individual is not in imminent danger of harm to self or others.
Service Exclusions	Intensive Day Treatment (Partial Hospitalization), Ambulatory Detoxification, ACT, and Crisis Residential.
Clinical Exclusions	Routine nursing activities that are included as a part of ambulatory detoxification, medication administration/methadone administration, or intensive day treatment.

Additional Service Criteria:

A. Required Components

1. This service does not include the supervision of self-administration of medication.

B. Staffing Requirements

1. These services must be offered by a licensed nurse within the scope of O.C.GA Practice Acts.
2. Practitioners providing this service are expected to maintain and utilize knowledge and skills regarding current research trends in best/evidence-based practices for psychiatric nursing and medication management.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

OPIOID MAINTENANCE TREATMENT

Definition of Service: An organized, usually ambulatory, addiction treatment service for opiate-addicted individuals. The service includes individualized treatment, case management, and health education (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]) (For Medicaid consumers, the actual administration of the opioid maintenance medication is conducted under the Medication Administration service code). The nature of the services provided (such as dose, level of care, length of service or frequency of visits) is determined by the patient's clinical needs, but such services always include regularly scheduled psychosocial treatment sessions and daily medication visits within a structured program. Services function under a defined set of policies and procedures, including admission, discharge and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. Length of service varies with the severity of the individual's illness, as well as his or her response to and desire to continue treatment. Treatment with methadone or LAAM is designed to address the individual's need to achieve changes in his or her level of functioning, including elimination of illicit opiate and other alcohol or drug use. To accomplish such change, the Individualized Recovery/Resiliency Plan must address major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of recovery and inhibit the individual's ability to cope with life.

Target Population	Individuals with a diagnosis of Opioid Dependence.
Initial Authorization	365 days
Re-Authorization	365 days
Authorization Period	365 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 310 – Opioid Maintenance — 08 – Outpatient
UAS: **Budget and Expense Categories**	Opioid Maintenance Therapy Provider 763 – Adult Addictive Diseases
Medicaid:	Not a Medicaid billable service (utilize the following service): Addictive Diseases Y3012 – Medication Administration
Admission Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.

Continuing Stay Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Discharge Criteria	Must meet criteria established by the Georgia Regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.
Service Exclusions	
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Must meet and follow criteria established by the Georgia regulatory body for opioid administration programs (Department of Human Resources, Office of Regulatory Services) and the Food and Drug Administration's guidelines for this service.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service. For Medicaid recipients who need opioid maintenance, the Medication Administration service should be utilized in place of the Opioid Maintenance Treatment service (see Medication Administration service definition and requirements).

F. Reporting Requirements

1. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.

PEER SUPPORT SERVICES

Definition of Service: This service provides structured activities within a peer support center that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are consumer motivated, initiated and/or managed, and assist individuals in living as independently as possible. Activities must promote self-directed recovery by exploring consumer purpose beyond the identified mental illness, by exploring possibilities of recovery, by tapping into consumer strengths related to illness self management, by emphasizing hope and wellness, by helping consumers develop and work toward achievement of specific personal recovery goals (which may include attaining meaningful employment if desired by the individual), and by assisting consumers with relapse prevention planning. A Consumer Peer Support Center may be a stand-alone center or housed as a "program" within a larger agency, and must maintain adequate staffing support to enable a safe, structured recovery environment in which consumers can meet and provide mutual support.

A Peer Support Center must be operated at a minimum of 3 days per week, no less than 4 hours per day during those three days. Any agency may offer additional hours on additional days without these minimum requirements.

Target Population	Adults with serious mental illness or co-occurring mental illness and substance related disorders Adolescents transitioning into adulthood with SED or co-occurring SED and substance related disorders
Initial Authorization	900 units (unit = 1 hour)
Re-Authorization	900 units (unit = 1 hour)
MHMRIS: **Subunit & Modality**	Subunit / Modality 328 – Peer Support / 08 – Outpatient
UAS: **Budget and Expense Categories**	Peer Support Services Provider 138 – Adult Mental Health 238 – C&A Mental Health 738 – Adult Addictive Diseases 838 – C&A Addictive Diseases
Medicaid:	Mental Health Y3022 – Peer Support for Adults

Admission Criteria	1. Individual must have a primary mental health issue; **and one or more of the following:** 2. Individual requires and will benefit from support of peer professionals for the acquisition of skills needed to manage symptoms and utilize community resources; **or** 3. Individual may need assistance to develop self-advocacy skills to achieve decreased dependency on the mental health system; **or** 4. Individual may need assistance and support to prepare for a successful work experience; **or** 5. Individual may need peer modeling to take increased responsibilities for his/her own recovery; **or** 6. Individual may need peer supports to develop or maintain daily living skills.
Continuing Stay Criteria	1. Individual continues to meet admission criteria; **and** 2. Progress notes document progress relative to goals identified in the Individualized Recovery/Resiliency Plan, but treatment/recovery goals have not yet been achieved.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Goals of the Individualized Recovery/Resiliency Plan have been substantially met; **or** 3. Consumer/family requests discharge; **or** 4. Transfer to another service/level is more clinically appropriate.
Service Exclusions	Crisis Stabilization Program (however, those utilizing transitional beds within a Crisis Stabilization Program may access this service).
Clinical Exclusions	1. Individuals diagnosed with a Substance-Related Disorder and no other concurrent mental illness; **or** 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury.

Additional Service Criteria:

A. Required Components

1. A Peer Supports service may operate as a program within:
   - A freestanding Peer Support Center
   - A Peer Support Center that is within a clinical service provider
   - A larger clinical or community human service provider administratively, but with complete programmatic autonomy.

2. A Peer Supports service must be operated for no less than 12 hours a week, no less than 4 hours per day, no less than 3 days per week, typically during day, evening and weekend hours.
3. The governing board of a freestanding Peer Center must be composed of 75% consumers and represent the cultural diversity of the population of the community being served. The board is encouraged to have either board members or operating relationships with someone with legal and accounting expertise. For programs that are part of a larger organizational structure that is not consumer led and operated, the Peer Supports Program must have an advisory body with the same composition as a freestanding Peer Center's board. The board or advisory committee must have the ability to develop programmatic descriptions and guidelines (consistent with state and federal regulations, accreditation requirements, and sponsoring agency operating policies), review and comment on the Peer Support Program's budgets, review activity offerings, and participate in dispute resolution activities for the program.
4. Individuals participating in the service at any given time must have the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, and about the schedule of those activities and services, as well as other operational issues.
5. Regardless of organizational structure, the service must be directed and led by consumers themselves.
6. Peer Supports may include meals or other social activities for purpose of building peer relationships, but meals cannot be the central or core activity offered. The focus of the service must be skill maintenance and enhancement and building individual consumer's capacity to advocate for themselves and other consumers.
7. Peer Supports cannot operate in isolation from the rest of the programs within the facility or affiliated organization. The Program Leader must be able to call multidisciplinary team meetings regarding a participating individual's needs and desires, and a Peer Specialist providing services for and with a participating individual must be allowed to participate in multidisciplinary team meetings.

B. Staffing Requirements

1. The program must be under the clinical supervision of a Mental Health Professional preferably a consumer who is a Georgia-certified Peer Specialist, and preferably who is credentialed by the United States Psychiatric Rehabilitation Association (USPRA) as an Associate Psychosocial Rehabilitation Professional (APRP) or Registered Psychiatric Rehabilitation Professional (RPRP), or staff who can demonstrate activity toward attainment of certification as a Certified Psychiatric Rehabilitation Professional (CPRP).[1] All staff are encouraged to seek and obtain Georgia certification as a Peer Specialist and the CPRP credential.

[1] NOTE: The United States Psychiatric Rehabilitation Association (usPRA) has changed its registration of professionals from APRP and RPRP to CPRP. This process will allow currently registered individuals a until June 30, 2005 to complete the training and testing required for the new certification as a CPRP. After that date, the APRP and RPRP registration will end. Professionals seeking certification for the first time are required to follow the CPRP certification requirements.

2. The individual leading and managing the day-to-day operations of the program must be a Georgia-certified Peer Specialist, who is an APRP, RPRP, or CPRP or can demonstrate activity toward attainment of the CPRP credential.
3. The Program Leader must be employed by the sponsoring agency at least 0.5 FTE.
4. The Program Leader and Georgia-certified Peer Specialists in the Peer Supports program may be shared with other programs as long as the Program Leader is present at least 75% of the hours the Peer Supports program is in operation, and as long as the Program Leader and the Georgia- certified Peer Specialists are available as required for supervision and clinical operations, and as long as they are not counted in consumer to staff ratios for 2 different programs operating at the same time.
5. Services must be provided and/or activities led by staff who are Georgia-certified Peer Specialists or other consumers under the supervision of a Georgia-certified Peer Specialist. A specific activity may be led by someone who is not a consumer but is an invited guest.
6. There must be at least 2 Georgia-certified Peer Specialists on staff either in the Peer Supports Program or in a combination of Peer Supports and other programs and services operating within the agency.
7. The maximum face-to-face ratio cannot be more than 30 consumers to 1 certified Peer Specialist based on average daily attendance of consumers in the program.
8. The maximum face-to-face ratio cannot be more than 15 consumers to 1 direct service/program staff, based on the average daily attendance of consumers in the program.
9. All staff must have an understanding of recovery and psychosocial rehabilitation principles as defined by the Georgia Consumer Council and psychosocial rehabilitation principles published by usPRA and must possess the skills and ability to assist other consumers in their own recovery processes.

C. Clinical Operations

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities may take place offsite in natural community settings as appropriate for the Individualized Recovery/Resiliency Plan (IRP) developed by each consumer with assistance from the Program Staff.
2. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Peer Supports program is in operation except as noted above.
3. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the Peer Supports program must not be substantially different from space provided for other uses for similar numbers of individuals.
4. Staff of the Peer Supports Program must be treated as equal to any other staff of the facility or organization and must be provided equivalent opportunities for training

(both mandated and offered) and pay and benefits competitive and comparable to other staff based on experience and skill level.

5. Weekly progress notes must document individual progress relative to functioning and skills related to goals identified in the IRP.
6. Daily attendance of each consumer participating in the program must be documented for billing purposes.
7. When this service is used in conjunction with Psychosocial Rehabilitation and ACT, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts. Utilization of this service in conjunction with these services is subject to review by the External Review Organization.
8. Consumers should set their own individualized goals and assess their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the consumer's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
9. Each consumer must be provided the opportunity for peer assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
10. A Peer Supports Program must offer a range of skill-building and recovery activities developed and led by consumers. These activities must include those that will most effectively support achievement of the consumer's rehabilitation and recovery goals.
11. The program must have a Peer Supports Organizational Plan addressing the following:
    - A service philosophy reflecting recovery principles as articulated by the Georgia Consumer Council, August 1, 2001. This philosophy must be actively incorporated into all services and activities and:
      (a) View each individual as the director of his/her rehabilitation and recovery process
      (b) Promote the value of self-help, peer support, and personal empowerment to foster recovery
      (c) Promote information about mental illness and coping skills
      (d) Promote peer-to-peer training of individual skills, social skills, community resources, and group and individual advocacy
      (e) Promote supported employment and education to foster self-determination and career advancement
      (f) Support each individual to "get a life" using community resources to replace the resources of the mental health system no longer needed
      (g) Support each individual to fully integrate into accepting communities in the least intrusive environment that promote housing of his/her choice
      (h) Actively seek ongoing consumer input into program and service content so as to meet each individual's needs and goals and foster the recovery process
    - A description of the particular consumer empowerment models utilized, types of activities offered, and typical daily activities and schedule; if offered, meals

must be described as an adjunctive peer relationship building activity rather than as a central activity.

- A description of the staffing pattern, plans for staff who have or will have achieved Peer Specialist and CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
- A description of how consumer staff within the agency are given opportunities to meet with or otherwise receive support from other consumers (including Georgia-certified Peer Specialists) both within and outside the agency.
- A description of how consumers are encouraged and supported to seek Georgia certification as a Peer Specialist through participation in training opportunities and peer or other counseling regarding anxiety following certification.
- A description of test-taking skills and strategies, assistance with study skills, information about training and testing opportunities, opportunities to hear from and interact with consumers who are already certified, additional opportunities for consumer staff to participate in clinical team meetings at the request of a consumer, and the procedure for the Program Leader to request a team meeting.
- A description of the hours of operation, the staff assigned, and the types of services and activities provided for and by consumers as well as for families, parents, and/or guardians.
- A description of the program's decision-making processes including how consumers direct decision-making about both individual and program-wide activities and about key policies and dispute resolution processes.
- A description of how consumers participating in the service at any given time are given the opportunity to participate in and make decisions about the activities that are conducted or services offered within the Peer Supports program, about the schedule of those activities and services, and other operational issues.
- A description of the space, furnishings, materials, supplies, transportation, and other resources available for individuals participating in the Peer Supports services.
- A description of the governing body and/or advisory structures indicating how this body/structure meets requirements for consumer leadership and cultural diversity.
- A description of how the plan for services and activities is modified or adjusted to meet the needs specified in each IRP.
- A description of how consumer requests for discharge and change in services or service intensity are handled.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

PHARMACY

Definition of Service: Directly or through a subcontract, prepare, compound, preserve, store, protect, and dispense prescribed medications; and assure appropriate instructions are provided as to the use of prescribed medications. These functions are coupled with patient and staff education and pharmacological monitoring to ensure safe and effective use of prescribed medications.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Initial Authorization	
Re-Authorization	
Authorization Period	
MHMRIS: **Subunit & Modality**	Subunit: 352 – Pharmacy Services Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	Core Services Provider 125 – Adult Mental Health 225 – C&A Mental Health 725 – Adult Addictive Diseases 825 – C&A Addictive Diseases
Medicaid:	Not a Medicaid Rehabilitation Option service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.
Admission Criteria	Individual has been assessed by a prescribing professional to need a psychotropic, anti-cholinergic, addiction specific, or anti-convulsant (as related to behavioral health issue) medication.
Continuing Stay Criteria	Individual continues to meet the admission criteria as determined by the prescribing professional
Discharge Criteria	1. Individual no longer demonstrates symptoms that are likely to respond to or are responding to pharmacologic interventions; **or** 2. Individual requests discharge and individual is not imminently dangerous or under court order for this intervention.
Service Exclusions	
Clinical Exclusions	

Additional Service Requirements:

A. Required Components

1. Service must be provided by a licensed pharmacy or through contract with a licensed pharmacy.
2. Agency must participate in any pharmaceutical rebate programs or pharmacy assistance programs which promote consumer access in obtaining medication.

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not a Medicaid Rehabilitation Option service. Medicaid recipients may access the general Medicaid pharmacy program as prescribed by the Department of Community Health.

F. Reporting Requirements

1. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.

PHYSICIAN ASSESSMENT AND CARE

Definition of Service: The provision of specialized medical and/or psychiatric services that include, but are not limited to:

1) Evaluation and assessment of physiological phenomena (including co-morbidity between behavioral and physical health care issues),
2) A psychiatric diagnostic evaluation (including assessing for co-occurring disorders and the development of a differential diagnosis),
3) Medical or psychiatric therapeutic services,
4) Assessment and monitoring of an individual's status in relation to treatment with medication, the development and authorization of the proposed support service array,
5) Assessment of the appropriateness of initiating or continuing services, and
6) Screening and/or assessment of any withdrawal symptoms for individuals with substance related diagnoses.

Individuals must receive appropriate medical interventions as prescribed and provided by a physician that shall support the individualized goals of recovery/resiliency as identified by the individual and their Individualized Recovery/Resiliency Plan.

Target Population	Individuals with Mental Illness or Substance Related Disorders
Initial Authorization	Total outpatient bundle = 200 units (unit = 15 minutes)
Re-Authorization	200 units
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit: 305 – Physician Assessment and Care Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	Core Services Provider 122 – Adult Mental Health 222 – C&A Mental Health 722 – Adult Addictive Diseases 822 – C&A Addictive Diseases
Medicaid:	Mental Health Y3007 – Physician Assessment and Care Addictive Diseases Y3007 – Physician Assessment and Care

Admission Criteria	1. Individual has a mental illness or a substance-related disorder and has recently entered the service system; **or** 2. Individual is in need of annual assessment and re-authorization of service array; **or** 3. Individual has been prescribed medications as a part of the treatment array; **or** 4. Individual has confounding medical issues which interact with behavioral health diagnosis, requiring medical oversight; **or** 5. Individual has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	1. Individual continues to meet the admission criteria; **or** 2. Individual exhibits acute disabling conditions of sufficient severity to bring about a significant impairment in day-to-day functioning; **or** 3. Individual continues to present symptoms that are likely to respond to pharmacological interventions; **or** 4. Individual continues to demonstrate symptoms that are likely to respond or are responding to medical interventions.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual has withdrawn or been discharged from service; **or** Individual no longer demonstrates symptoms that need pharmacological interventions.
Service Exclusions	Not offered in conjunction with Intensive Day Treatment, ACT, or Crisis Stabilization Programs.
Clinical Exclusions	Services defined as a part of ambulatory detoxification, ACT, Crisis Stabilization Programs, and Intensive Day Treatment.

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

1. Practitioners providing this service are expected to maintain and utilize knowledge and skills regarding current research trends in best/evidence-based practices for psychiatry and medication management.
2. This service must be provided by a licensed medical physician with behavioral health training in accordance with the O.C.G.A and the Professional Practice Acts.
3. This service may also be provided by a Clinical Nurse Specialist or a Physician's Assistant with behavioral health training in accordance with O.C.G.A and the Professional Practice Acts (non-Medicaid only).

C. Clinical Operations

1. In accordance with recovery philosophy, it is expected that individuals will be treated as full partners in the treatment regimen/services planned and received. As such, it is expected that practitioners will fully discuss treatment options with individuals and allow for individual choice when possible. Discussion of treatment options should include a full disclosure of the pros and cons of each option (e.g. full disclosure of medication/treatment regimen potential side effects, potential adverse reactions--including potential adverse reaction from not taking medication as prescribed, and expected benefits). If such full discussion/disclosure is not possible or advisable according to the clinical judgment of the practitioner, this should be documented in the individual's chart (including the specific information that was not discussed and a compelling rationale for lack of discussion/disclosure).

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients, only a licensed medical physician as described in the staffing requirements above may provide this service.
2. Currently, there are no other additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

RESIDENTIAL SUBSTANCE DETOXIFICATION

Definition of Service: Residential Substance Detoxification is an organized and voluntary service that may be delivered by appropriately trained staff who provide 24-hour per day, 7 day per week supervision, observation and support for individuals during detoxification. Residential detoxification is characterized by its emphasis on medical monitoring and/or on peer/social support, and should reflect a range of residential detoxification service intensities from ASAM (American Society of Addiction Medication) Level III.2D to III.7D. These levels provide care for individuals whose intoxication/withdrawal signs and symptoms may only require 24-hour supervision, observation and support by appropriately trained staff with an emphasis on peer/social support that cannot be provided by the individual's natural support system, or that are sufficiently severe enough to require 24-hour medically monitored withdrawal management and support from medical and nursing professionals in a permanent facility with inpatient beds. All programs at these levels rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of service.

Target Population	Adults and Adolescents with a diagnosis of one of the following: 303.00 291.81 291.0
Initial Authorization	30 days
Re-Authorization	30 days
Authorization Period	30 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 721 – Residential Detox — 04 – Residential
UAS: **Budget and Expense Categories**	Substance Abuse Detox Services Provider 765 – Adult Addictive Diseases 865 – C&A Addictive Diseases
Medicaid:	If appropriate utilize service below: Addictive Diseases Y3035 – Rehab Supports in Residential Alternatives – Level 2

Admission Criteria	1. Individual has a Substance Induced Disorder as defined in the latest version of the DSM (ASAM PPC-2, Dimension-1 and is experiencing signs of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional/behavioral condition) that severe withdrawal syndrome is imminent; and is assessed as manageable at this level of service; **and** 2. There is strong likelihood that the individual will not complete detoxification at another level of service and enter into continued treatment or self-help recovery **as evidenced by one of the following**: a. individual requires medication and has recent history of detox at a less intensive service level, marked by past and current inability to complete detox and enter continuing addiction treatment; individual continues to lack skills or supports to complete detox, **or** b. individual has a recent history of detox at less intensive levels of service marked by inability to complete detox or enter into continuing addiction treatment and continues to have insufficient skills to complete detox, **or** c. individual has co-morbid physical or emotional/behavioral condition that is manageable in a Level III.7-D setting but which increases the clinical severity of the withdrawal and complicates detoxification.
Continuing Stay Criteria	Individual's withdrawal signs and symptoms are not sufficiently resolved so that the individual can be managed in a less intensive service.
Discharge Criteria	1. An adequate continuing care plan has been established; and one or more of the following: 2. Goals of the Individualized Recovery/Resiliency Plan have been substantially met; **or** 3. Individual/family requests discharge and individual is not in imminent danger of harm to self or others; or Individual's signs and symptoms of withdrawal have failed to respond to treatment and have intensified (as confirmed by higher scores on the CIWA-Ar or other comparable standardized scoring system), such that transfer to a Level IV-D detoxification service is indicated.
Service Exclusions	ACT, Nursing Assessment and Medication Administration (Medication administered as a part of Residential Detoxification is not to be billed as Medication Administration.)
Clinical Exclusions	1. Concomitant medical condition and/or other behavioral health issues warrant inpatient treatment or Crisis Stabilization Program admission.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. A physician's order in the individual's record is required to initiate a detoxification regimen.
3. Medication administration may be initiated only upon the order of a physician.
4. Verbal orders or those initiated by a Physician's Assistant or Clinical Nurse Specialist are acceptable provided they are signed by the physician within 24 hours or the next working day.

B. Staffing Requirements

1. Services must be provided by a combination of nursing, other licensed medical staff, and other residential support under supervision of a physician.
2. In programs that are designed to target adolescent treatment, staffing patterns must reflect staff expertise in the delivery of services to that age population. In addition, higher staffing ratios would be expected in these programs related to supervision.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. For Medicaid recipients, this service may be billed as Rehabilitative Supports for Individuals in Residential Alternatives – Level 2. Please see the Rehabilitative Supports for Individuals in Residential Alternatives – Level 2 service definition for service requirements.

F. Reporting Requirements

1. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.

RESIDENTIAL SUPPORTS

Definition of Service: Provides a variety of community living arrangements and ranges of training and supervision to meet a broad range of needs. The particular type of residential services an individual receives over time should vary according to the fluctuating needs of that individual. Based on individuals' needs, residential services may be highly structured, heavily supervised, and programmatically intensive, or the residential service may facilitate a relatively independent lifestyle requiring only a modest amount of staff support. Residential services should be a part of the community and the environment and size of the residential option should blend in with the surrounding homes. Whenever possible, people should be supported in their natural homes, particularly those under age 22.

The following Residential Supports are provided:

- **Independent Living Supports**
- **Skills Training and Supported Living**
- **Structured Living Supports**
- **Intensive Living Supports**
- **Therapeutic Foster Care**
- **Therapeutic Group Home**

Refer to the service definitions on the following pages.

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports, Community Support-Individual (CSI), or Community Support-Team (CST) should be cross-referenced for any associated rules and requirements.

INDEPENDENT LIVING SUPPORTS

Definition of Service: This is the least intensive level of support in residential services. Individuals that need this service have basic self care skills, communication skills or systems, are able to recognize emergency situations and get help, and have the ability to learn most daily and home living skills but may need some training, supervision, or assistance. They are ambulatory or mobile non-ambulatory with transfer skills, and in good health. They may need advice or assistance with social situations, finances, medications and transportation. They have no major difficulty with behaviors. Supports provided may include assistance with medication management, daily living skills, dietary, community education and socialization. Services may be offered less than 24 hours a day, seven days a week.

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports, Community Support-Individual (CSI), or Community Support-Team (CST) should be cross-referenced for any associated rules and requirements.

Target Population	Adults with Serious Mental Illness, Children and Adolescents with Severe Emotional Disturbance, Children, Adolescents and Adults with Substance Related Disorders, Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and Mental Illness Children, Adolescents and Adults with Co-Occurring Mental Illnesses and MR/DD. Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and MR/DD.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 506 – Independent Living Supports — 04 – Residential
UAS: **Budget and Expense Categories**	Residential Services Provider 141 – Adult Mental Health 241 – C&A Mental Health 741 – Adult Addictive Diseases 841 – C&A Addictive Diseases

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

Medicaid:	Utilize the following Medicaid services as appropriate: **Independent Living Supports** <u>Mental Health</u> Y3030 – Community Support Individual Y3036 – Community Support Team <u>Addictive Diseases</u> Y3030 – Community Support Individual Y3036 – Community Support Team
Admission Criteria	1. Individual must have symptoms of mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition.
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.

Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 3. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to individuals with mental illness/SED and/or substance related diagnoses.
2. An agency that provides financial assistance which enables a consumer to access housing supports must adequately document all financial transactions which allow the DMHDDAD to maintain accountability of funds distribution. Detailed documentation of expenditures will be required of providers during the FY06 contract year.
3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of consumers and their families.
2. All Residential Support Services must be supervised by a Mental Health Professional or an SAM.
3. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
   a. Evidence of licensure, certification or registration as applicable and as required by the job being performed
   b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
   c. Appropriate references and background check
   d. A process by which all staff, as a condition of hiring, must:

i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
ii. Indicate if they are presently using illegal drugs
iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.

4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services must be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required services.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation.

Each note must be signed and dated and must include the professional designation of the individual making the entry.

3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and wellbeing of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. Evacuation routes must be clearly marked by exit signs.
6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

SKILLS TRAINING AND SUPPORTED LIVING

Definition of Service: Persons needing this level of support have moderate functional self care skills but need regular training to refine those skills. They possess some skills or a system to communicate, can recognize danger or emergency situations and get assistance. They have the ability to learn home living skills but require regular training and assistance to become independent in the home. These persons would need training in basic first aid, finances, medication issues and transportation, or regular ongoing assistance in these areas. They are in good health, ambulatory, or mobile non-ambulatory, and may require assistance transferring. Assistance and guidance are needed to develop social relationships and they may need frequent advice regarding minor behavior issues or more structure in arranging and completing activities. Services locations supervised on site as needed. (Types of services in this level may include a range from supervised apartments to less intensive group home arrangements to long-term Substance Abuse residences.)

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports, Community Support-Individual (CSI), or Community Support-Team (CST) should be cross-referenced for any associated rules and requirements.

Target Population	Adults with Serious Mental Illness, Children and Adolescents with Severe Emotional Disturbance, Children, Adolescents and Adults with Substance Related Disorders, Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and Mental Illness Children, Adolescents and Adults with Co-Occurring Mental Illnesses and MR/DD. Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and MR/DD.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: Subunit & Modality	Subunit: 507 – Skills Training and Supported Living Modality: 11 – Supported Living

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UAS: **Budget and Expense Categories**	Residential Services Provider 143 – Adult Mental Health 243 – C&A Mental Health 743 – Adult Addictive Diseases 843 – C&A Addictive Diseases
Medicaid:	Utilize the following Medicaid services as appropriate: **Skills Training and Supported Living** <u>Mental Health</u> Y3030 – Community Support Individual Y3036 – Community Support Team Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2 <u>Addictive Diseases</u> Y3030 – Community Support Individual Y3036 – Community Support Team Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2
Admission Criteria	1. Individual must have symptoms of mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition.
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.

Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 3. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to individuals with mental illness/SED and/or substance related diagnoses.
2. An agency providing financial assistance that enables a consumer to access housing supports must adequately document all financial transactions to allow the DMHDDAD to maintain accountability of funds distribution. Detailed documentation of expenditures will be required of providers during the FY06 contract year.
3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers, must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of consumers and their families.
2. All Residential Support Services must be supervised by a Mental Health Professional or an SAM.
3. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
   a. Evidence of licensure, certification or registration as applicable and as required by the job being performed
   b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
   c. Appropriate references and background check
   d. A process by which all staff, as a condition of hiring, must:

i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
ii. Indicate if they are presently using illegal drugs
iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.

4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services must be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required services.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation.

Each note must be signed and dated and must include the professional designation of the individual making the entry.

3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and wellbeing of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. Evacuation routes must be clearly marked by exit signs.
6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

STRUCTURED LIVING SUPPORTS

Definition of Service: Persons needing this residential service often have significant deficits in independent living skills and need extensive support and supervision. Services include training and assistance in many areas of self-care, symptom management and in recognizing and avoiding dangerous situations. Regular and consistent training would be needed in most areas of daily and home living. Individuals may need training in verbal communication or may require an alternate communication system. Individuals may be ambulatory or may need assistance, or adaptive equipment. They may also need close medical management or behavioral management. Major behavior difficulties would not occur daily but may be of such frequency as to require behavior plans and technical interventions. Individuals will need continual supervision and training on medication issues and symptom management. These services are typically structured rehabilitation/habilitation oriented group facilities that have 24-hour supervision available. (Included in this level of services are group homes with moderate supports, adolescent substance abuse residential services, and transitional group homes for adolescents with SED.)

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports, Community Support-Individual (CSI), or Community Support-Team (CST) should be cross-referenced for any associated rules and requirements.

Target Population	Adults with Serious Mental Illness, Children and Adolescents with Severe Emotional Disturbance, Children, Adolescents and Adults with Substance Related Disorders, Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and Mental Illness Children, Adolescents and Adults with Co-Occurring Mental Illnesses and MR/DD. Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and MR/DD.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

MHMRIS: **Subunit & Modality**	Subunit — Modality 511 – Structured Living Supports - Residential — 04 – Residential 512 – Structured Living Supports - Group Home — 09 – Group Home
UAS: **Budget and Expense Categories**	Residential Services Provider 144 – Adult Mental Health 244 – C&A Mental Health 744 – Adult Addictive Diseases 844 – C&A Addictive Diseases
Medicaid:	Utilize the following Medicaid services as appropriate: **Structured Living Supports** Mental Health Y3034 –Rehab Supports in Residential Alternatives– Level 1 (see following code) Y3035 –Rehab Supports in Residential Alternatives – Level 2 (see following code) Addictive Diseases Y3034 – Rehab Supports in Residential Alternatives 1 (see following code) Y3035 – Rehab Supports in Residential Alternatives 2 (see following code)
Admission Criteria	1. Individual must have symptoms of mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.

Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.
Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 3. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to individuals with mental illness/SED and/or substance related diagnoses.
2. An agency providing financial assistance that enables a consumer to access housing supports must adequately document all financial transactions to allow the DMHDDAD to maintain accountability of funds distribution. Detailed documentation of expenditures will be required of providers during the FY06 contract year.
3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers, must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of consumers and their families.
2. All Residential Support Services must be supervised by a Mental Health Professional or an SAM.
3. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
   a. Evidence of licensure, certification or registration as applicable and as required by the job being performed

b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
c. Appropriate references and background check
d. A process by which all staff, as a condition of hiring, must:
    i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
    ii. Indicate if they are presently using illegal drugs
    iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.

4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services must be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also

include each week's programming/service schedule in order to document the provision of the required services.

2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and wellbeing of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. Evacuation routes must be clearly marked by exit signs.
6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

INTENSIVE LIVING SUPPORTS

Definition of Service: Persons needing intensive living supports are in need of 24-hour intensive supervision. Services provided include intensive medical, nursing or behavioral support as determined by a physician, or an interdisciplinary team. These individuals may need one-to-one staff to provide extensive training in areas of self-care, daily and home living or they may have other physical disabilities that must be addressed with adaptive equipment or additional professional and direct care staff. Closely monitored behavior plans, along with very specific training regimens, are necessary for individuals with extreme behavioral difficulties. Individuals may need this level of service for short periods of time or may require an intense level of training, supervision, and medical management indefinitely. (Intensive Living Supports would include substance abuse short-term (up to 30 days) residential treatment services, intensive treatment residences, and residential treatment services to children and adolescents in crisis. This service requires separate financial report in conformity with the SAPTBG.)

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports, Community Support-Individual (CSI), or Community Support-Team (CST) should be cross-referenced for any associated rules and requirements.

Target Population	Adults with Serious Mental Illness, Children and Adolescents with Severe Emotional Disturbance, Children, Adolescents and Adults with Substance Related Disorders, Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and Mental Illness Children, Adolescents and Adults with Co-Occurring Mental Illnesses and MR/DD. Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and MR/DD.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: Subunit & Modality	Subunit: 509 – Intensive Living Supports Modality: 04 – Residential

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

UAS: **Budget and Expense Categories**	Residential Services Provider 145 – Adult Mental Health 245 – C&A Mental Health 745 – Adult Addictive Diseases 845 – C&A Addictive Diseases
Medicaid:	Utilize the following Medicaid services as appropriate: **Intensive Living Supports** <u>Mental Health</u> Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2 <u>Addictive Diseases</u> Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2
Admission Criteria	1. Individual must have symptoms of mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition.
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.

Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 3. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to individuals with mental illness/SED and/or substance related diagnoses.
2. An agency providing financial assistance that enables a consumer to access housing supports must adequately document all financial transactions to allow the DMHDDAD to maintain accountability of funds distribution. Detailed documentation of expenditures will be required of providers during the FY06 contract year.
3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers, must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of consumers and their families.
2. All Residential Support Services must be supervised by a Mental Health Professional or an SAM.
3. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
   a. Evidence of licensure, certification or registration as applicable and as required by the job being performed
   b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
   c. Appropriate references and background check
   d. A process by which all staff, as a condition of hiring, must:

i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
ii. Indicate if they are presently using illegal drugs
iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.

4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services must be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required services.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation.

Each note must be signed and dated and must include the professional designation of the individual making the entry.

3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and wellbeing of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. Evacuation routes must be clearly marked by exit signs.
6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

THERAPEUTIC FOSTER CARE

Definition of Service: Twenty-four-hour specialized living arrangements for children unable to live with their parents/responsible caregiver(s). Services provide a family living environment with foster families specifically recruited and trained in approaches and techniques on working effectively with this population. When children and adolescents are living in a Therapeutic Foster Home, therapeutic foster parents are considered part of the treatment team and help develop and implement specific treatment plans for the individual. Each therapeutic foster care home has no more than a maximum of two children except in unusual circumstances such as sibling group, as long as clinically appropriate. Therapeutic foster care home providers may not serve other individuals under other types of service. A minimum of one licensed staff person supports every six homes and has their training and consultations duties outlined.

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports should be cross-referenced for any associated rules and requirements.

Target Population	Children and Adolescents with SED Children and Adolescents with Co-Occurring SED and Substance Related Disorders
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit: 501 – Therapeutic Foster Care Modality: 04 – Residential
UAS: **Budget and Expense Categories**	Residential Services Provider 246 – C&A Mental Health 846 – C&A Addictive Diseases

MH & AD SERVICES FOR CHILDREN, ADOLESCENTS AND ADULTS

Medicaid:	Utilize the following Medicaid services as appropriate: **Therapeutic Foster Care** Mental Health Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2 Addictive Diseases Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2
Admission Criteria	1. Individual must have symptoms of mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition.
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.

Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 3. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to individuals with mental illness/SED and/or substance related diagnoses.
2. An agency providing financial assistance that enables a consumer to access housing supports must adequately document all financial transactions to allow the DMHDDAD to maintain accountability of funds distribution. Detailed documentation of expenditures will be required of providers during the FY06 contract year.
3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers, must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of consumers and their families.
2. All Residential Support Services must be supervised by a Mental Health Professional or an SAM.
3. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
   a. Evidence of licensure, certification or registration as applicable and as required by the job being performed
   b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
   c. Appropriate references and background check
   d. A process by which all staff, as a condition of hiring, must:

i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
ii. Indicate if they are presently using illegal drugs
iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.

4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services must be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required services.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation.

Each note must be signed and dated and must include the professional designation of the individual making the entry.

3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and wellbeing of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. Evacuation routes must be clearly marked by exit signs.
6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

THERAPEUTIC GROUP HOME

Definition of Service: Twenty-four hour residential treatment home for Children and Adolescents with a severe emotional disturbance who are unable to live with their parents/responsible caregiver(s). The maximum number of individuals served in a Therapeutic Group Home is six. Services provide a structured, therapeutic home environment with trained staff to supervise the consumer, ensure their safety and guide them toward their treatment goals. Education services are provided through the public school system and staff provides community activities including recreation and leisure education. Individual, family and group therapy services are also provided.

* For agencies that bill Medicaid, the definition of Residential Rehabilitation Supports should be cross-referenced for any associated rules and requirements.

Target Population	Children and Adolescents with SED Children and Adolescents with Co-Occurring SED and Substance Related Disorders
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 503 – Therapeutic Group Home — 09 – Group Home
UAS: **Budget and Expense Categories**	Residential Services Provider 247 – C&A Mental Health 847 – C&A Addictive Diseases
Medicaid:	Utilize the following Medicaid services as appropriate: **Therapeutic Group Home** Mental Health Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2 Addictive Diseases Y3034 – Rehab Supports in Residential Alternatives 1 Y3035 – Rehab Supports in Residential Alternatives 2

Admission Criteria	1. Individual must have symptoms of mental illness or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition.
Service Exclusions	Cannot be billed on the same day as Crisis Residential or Residential Detoxification.
Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 2. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 3. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. If the residential support requires licensing by the Georgia Office of Regulatory Services, the organization must be appropriately licensed to provide residential services to individuals with mental illness/SED and/or substance related diagnoses.
2. An agency providing financial assistance that enables a consumer to access housing supports must adequately document all financial transactions to allow the DMHDDAD to maintain accountability of funds distribution. Detailed

documentation of expenditures will be required of providers during the FY06 contract year.

3. Agencies that are approved Medicaid *Rehabilitative Supports for Individuals in Residential Alternatives* providers, must reference that code for specific requirements related to provision of service.

B. Staffing Requirements

1. The organization must hire personnel with the qualifications necessary to provide Residential Supports and to meet the needs of consumers and their families.
2. All Residential Support Services must be supervised by a Mental Health Professional or an SAM.
3. The organization that provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
    a. Evidence of licensure, certification or registration as applicable and as required by the job being performed
    b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college transcripts, copy of college degree, documentation/certification for specialized training etc) as required.
    c. Appropriate references and background check
    d. A process by which all staff, as a condition of hiring, must:
        i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
        ii. Indicate if they are presently using illegal drugs
        iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.
4. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the types of services it offers that includes for this benefit, at a minimum, the purpose of the service; the intended population to be served; if appropriate, treatment modalities provided by the service; level of supervision and oversight provided; and typical clinical objectives and expected outcomes.

D. Service Access

E. Additional Medicaid Requirements

1. Depending upon the specific interventions to be employed, the Community Support-Individual, Community Support- Team, or Rehabilitative Supports for Individuals in Residential Alternatives Level 1 or 2 services must be billed for Medicaid recipients. See these service definitions for service requirements as appropriate.

F. Reporting Requirements

1. All applicable MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. If the organization is providing a traditional residential support services, it must develop and maintain sufficient written documentation to support the Residential Support Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Support Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required services.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Support being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and wellbeing of the residents.
2. Each residential facility must comply with all relevant fire safety codes.
3. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
4. The organization must comply with the American with Disabilities Act.
5. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted. Evacuation routes must be clearly marked by exit signs.

6. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

REHABILITATIVE SUPPORTS FOR INDIVIDUALS IN RESIDENTIAL ALTERNATIVES LEVEL 1 & 2

Definition of Service: Residential Rehabilitative Supports are comprehensive rehabilitative services to aid youth and adults in developing daily living skills, interpersonal skills, and behavior management skills; and to enable adults to manage symptoms and regain lost functioning due to mental illness, substance abuse, and/or co-occurring disorders. This service provides support and assistance to the youth and the family to identify, adjust, and manage symptoms; enhance participation in group living and community activities; and, develop positive personal and interpersonal skills and behaviors to meet the youth's dependency and developmental needs.

Services are delivered to individuals according to their specific needs. Individual and group activities and programming must consist of services to restore and develop skills in functional areas that interfere with the ability to live in the community, participate in educational activities; regain or maintain competitive employment; develop or maintain social relationships; or participate in social, interpersonal, recreational or community activities.

Rehabilitative services must be provided in a licensed residential setting with no more than 16 individuals and must include supportive counseling, psychotherapy and adjunctive therapy supervision, and recreational, problem solving, and interpersonal skills development. All facilities providing residential rehabilitative supports must be staffed 24 hours a day, 7 days a week.

Target Population	Adults with Serious Mental Illness, Children and Adolescents with Severe Emotional Disturbance, Children, Adolescents and Adults with Substance Abuse Issues, Children, Adolescents and Adults with Co-Occurring Substance Abuse and Mental Illness Children, Adolescents and Adults with Co-Occurring Mental Illnesses and MR/DD. Children, Adolescents and Adults with Co-Occurring Substance Related Disorders and MR/DD.
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: Subunit & Modality	Refer to the Residential Supports definitions for specific subunits.

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UAS: Budget and Expense Categories	Not applicable.
Medicaid:	Mental Health Y3034 –Rehab Supports in Residential Alternatives– Level 1 Y3035 –Rehab Supports in Residential Alternatives – Level 2 Addictive Diseases Y3034 –Rehab Supports in Residential Alternatives– Level 1 Y3035 –Rehab Supports in Residential Alternatives – Level 2
Admission Criteria	1. Individual must have symptoms of a mental illness/SED or a substance related disorder; **and one or more of the following:** 2. Individual's symptoms/behaviors indicate a need for continuous monitoring and supervision by 24-hour staff to ensure safety; **or** 3. Individual has insufficient or severely limited skills to maintain an adequate level of functioning, specifically identified deficits in daily living and social skills and/or community/family integration; **or** 4. Individual has adaptive behaviors that significantly strain the family's or current caretaker's ability to adequately respond to the individual's needs; **or** 5. Individual has a history of unstable housing due to a behavioral health issue or a history of unstable housing which exacerbates a behavioral health condition.
Continuing Stay Criteria	Individual continues to meet Admissions Criteria.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired rehabilitative skills to independently manage his/her own housing; **or** 3. Transfer to another service is warranted by change in individual's condition
Service Exclusions	Cannot be billed on the same day as Crisis Stabilization Program. Residential Rehabilitative Supports 1 and 2 cannot be billed simultaneously.

Clinical Exclusions	1. Severity of identified individual issues precludes provision of services in this service 2. Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, or traumatic brain injury. 3. Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services). 4. Individual can effectively and safely be supported with a lower intensity service.

Additional Service Criteria:

A. Required Components

1. The organization must have an executive director or program director charged with the responsibility for day-to-day management of the organization.
2. The organization must be licensed by the Georgia Office of Regulatory Services to provide residential services to individuals with mental illness and/or substance abuse diagnosis.
3. The residential program must provide a structured and supported living environment 24 hours a day, 7 days a week.
4. Level I Residential Rehabilitation Services must provide 4 hours per week of structured programming and/or services.
5. Level II Residential Rehabilitation Services must provide 6 hours per week of structured programming and/or services.

B. Staffing Requirements

1. All Residential Rehabilitation Services must be provided by a Mental Health Professional or SAM, or a paraprofessional under the supervision of a Mental Health Professional or SAM.
2. Facilities must comply with any staffing requirements set forth for mental health and substance abuse facilities by the Office of Regulatory Services.
3. All Residential Support Services must be supervised by a Mental Health Professional or SAM.
4. The organization which provides direct residential services must have written policies and procedures for selecting and hiring residential and clinical staff that include:
   a. Evidence of licensure, certification or registration as applicable and as required by the job being performed.
   b. For unlicensed clinical staff, evidence of completion of an appropriate degree or training program (i.e., documentation of GED/high school diploma, college

transcripts, copy of college degree, documentation/certification for specialized training etc) as required.

c. Appropriate references and background check
d. A process by which all staff, as a condition of hiring, must:
    i. Declare any past events that might raise liability or risk management concerns, such as malpractice actions, insurance cancellations, criminal convictions, Medicare/Medicaid sanctions, and ethical violations
    ii. Indicate if they are presently using illegal drugs
    iii. Attest that they are capable of performing the essential functions of their jobs with or without accommodation.

5. The organization must have a mechanism for ongoing monitoring of staff licensure, certification, or registration such as an annual confirmation process concurrent with a performance evaluation that includes repeats of screening checks outlined above.

C. Clinical Operations

1. The organization must have a written description of the Residential Rehabilitation services it offers that includes, at a minimum, the purpose of the service; the intended population to be served; treatment modalities provided by the service; level of supervision and oversight provided; and typical treatment objectives and expected outcomes.
2. Residential Rehabilitation Services assist individuals in developing daily living skills that enable them to manage the symptoms of and regain functioning lost due to their psychiatric or addictive disorder. Services must be delivered to individuals according to their specific needs. Individual and group activities and programming consists of services geared toward restoring and developing skills in functional areas that interfere with the individual's ability to live in the community, live independently, regain or maintain competitive employment, develop or maintain social relationships, or independently participate in social, interpersonal, or community activities.
3. Residential Rehabilitation Services must include symptom management or supportive counseling; medication education, training and support; support, supervision, and problem solving skill development; development of community living skills that serve to promote independent utilization of community-based services; and/or social or recreational skill training to improve communication skills, manage symptoms, and facilitate appropriate interpersonal behavior.

D. Service Access

E. Additional Medicaid Requirements

1. This is a Medicaid-billable service and is subject to all Medicaid policies, procedures, and rules.
2. This is a Medicaid-billable service only, not a state-funded service. The Residential Supports service or other housing support services (e.g. CSI, CST, ACT etc) should be billed as appropriate for individuals who do not receive Medicaid. Please see the

Residential Supports service definitions or other applicable service definitions for service requirements.
3. Any facility billing this service may not exceed 16 beds.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. The organization must develop and maintain sufficient written documentation to support the Residential Rehabilitation Service for which billing is made. This documentation, at a minimum, must confirm that the individual for whom billing is requested was a resident of the Residential Rehabilitation Service on the date of service. The individual's record must also include each week's programming/service schedule in order to document the provision of the required amount of service.
2. Weekly progress notes must be entered in the individual's record to enable the monitoring of the individual's progress toward meeting treatment and rehabilitation goals and to reflect the Individualized Recovery/Resiliency Plan implementation. Each note must be signed and dated and must include the professional designation of the individual making the entry.
3. Documentation must be legible and concise and include the printed name and the signature of the treating practitioner. The name, title, and credentials of the individual providing the service must reflect the staffing requirements established for the Rehabilitation Service being delivered.

H. Facilities Management (applicable to traditional residential settings such as group homes, treatment facilities, etc)

1. Residential Rehabilitation Services may only be provided in facilities that have no more than 16 beds.
2. Each residential facility must be arranged and maintained to provide adequate measures for the health, safety, access and well being of the residents.
3. Each residential facility must comply with all relevant fire safety codes.
4. All areas of the residential facility must appear clean, safe, appropriately equipped, and furnished for the services delivered.
5. The organization must comply with the American with Disabilities Act.
6. The organization must maintain a written evacuation plan to be used in the case of fire or other disaster. An appropriate written certificate of compliance must be obtained indicating that all applicable fire and safety code requirements have been satisfied. Periodic fire drills must be conducted.
7. Evacuation routes must be clearly marked by exit signs.

8. The program must be responsible for providing physical facilities that are structurally sound and that meet all applicable federal, state, and local regulations for adequacy of construction, safety, sanitation, and health.

RESPITE

Definition of Service: Respite services are brief periods of support or relief for family/ responsible caregiver(s) of individuals with mental illnesses and/or substance related disorders. Respite is provided: (1) when an individual is experiencing a psychiatric, substance related or behavioral crisis and needs structured, short-term support; (2) when families/responsible caregiver(s) are in need of additional support or relief; or (3) when the individual and family/responsible caregiver(s) experience the need for therapeutic relief from the stresses of their mutual cohabitation. Respite may be provided in-home (i.e. provider delivers service in individual's home) or out-of-home (individual receives service outside of their home), and may include day activities as well as overnight activities/accommodations as appropriate to the situation.

Target Population	Adults experiencing: Severe and Persistent Mental Illness Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation Children and Adolescents experiencing: SED Substance-Related Disorders Co-Occurring Substance-Related Disorders and Mental Illness Co-Occurring Mental Illness and Mental Retardation Co-occurring Substance-Related Disorders and Mental Retardation
Initial Authorization	While the actual respite should be very short-term in nature, this service can be authorized as part of a 180 day Recovery/Resiliency plan.
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit / Modality 110 – Respite – In-Home / 04 – Residential 111 – Respite – Out of Home / 08 – Outpatient
UAS: **Budget and Expense Categories**	Consumer/Family Support Services Provider 136 – Adult Mental Health 236 – C&A Mental Health 736 – Adult Addictive Diseases 836 – C&A Addictive Diseases
Medicaid:	NONE

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Admission Criteria	1. Individual meets target population as identified above; **and** 2. Individual has a need for short-term support which could delay or prevent the need for out-of-home placement or higher levels of service intensity (such as acute hospitalization); **and one or more of the following:** 3. Individual has a circumstance which destabilizes his/her current living arrangement and the provision of this service would provide short-term relief and support of the individual; **or** 4. For a child, the family has an immediate need for support and relief from the responsibility and stress of managing behavioral health issues; **or** 5. For a child, the family has an immediate need to participate in an emergency event during which lack of supervision may cause the child a set-back in his/her Resiliency plan.
Continuing Stay Criteria	1. Individual continues to meet admission criteria as defined above; **and** 2. Individual has developed a Recovery/Resiliency goal to develop natural supports that promote the self/family-management of these needs.
Discharge Criteria	1. Individual/family requests discharge; **or** 2. Individual has acquired natural supports that supplant the need for this service.
Service Exclusions	Traditional 24/7 Residential Supports (Service may be provided in addition to Therapeutic Foster Care on a limited basis to preserve placement).
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, traumatic brain injury. 1) Individual is actively using unauthorized drugs or alcohol (which should not indicate a need for discharge, but for a review of need for more intensive services).

Additional Service Criteria:

A. Required Components

B. Staffing Requirements

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid-billable service.

F. Reporting Requirements

1. Enrollments to MHMRIS for Respite – Residential requires that a consumer be enrolled and released each time the consumer receives the service and may not be left open as an open enrollment. For Respite – Outpatient a consumer may be enrolled in this service and left open if the service is a part of the consumer's treatment plan and the consumer is to receive this on a continuous basis.
2. All other applicable MHMRIS and DMHDDAD reporting requirements must be adhered to.

SCREENING, TRIAGE AND REFERRAL

Definition of Service: This service includes the brief assessment of an individual's need for services to determine whether there are sufficient indications of a behavioral health issue to warrant further evaluation. This service also includes the initial gathering of information to identify the urgency of need. This information is collected through a brief face-to-face or telephonic interview with the consumer or significant other as necessary. This service includes the process of obtaining cursory historical, social, functional, psychiatric, developmental, or other information from the individual and/or family seeking services in order to determine whether or not a behavioral health issue is likely to exist and urgency of the need. Services are available 24 hours per day/7 days a week. This service also includes the provision of appropriate triage and referrals to needed services based on the individual's presentation and preferences as identified in the screening process.

Target Population	A known or suspected mental health diagnosis and/or Substance-Related Disorder.
Initial Authorization	None Required
Re-Authorization	None Required
Authorization Period	None Required
MHMRIS: **Subunit & Modality**	Subunit — Modality 901 – Service Entry and Linkage — 08 – Outpatient
UAS: **Budget and Expense Categories**	Single Point of Entry Services Provider 131 – Adult Mental Health 231 – C&A Mental Health 731 – Adult Addictive Diseases 831 – C&A Addictive Diseases
Medicaid:	When a basic screening transitions into the gathering of assessment information, then Diagnostic Assessment may be billed in accordance with that definition.
Admission Criteria	A known or suspected mental illness and/or substance-related disorder
Continuing Stay Criteria	
Discharge Criteria	When screening, triage, and referral activities are completed and consumer is referred.
Service Exclusions	
Clinical Exclusions	

Additional Service Criteria:

A. Required Components

1. Only providers designated contractually to provide this service may bill this code.
2. The agency must follow and adhere to the Single Point of Entry Core Functions and Operational Definitions document which is a part of the DMHDDAD contract manual.
3. In emergency situations, contractors shall screen, triage and connect the consumer to a crisis service. The crisis service must be scheduled to be received by the consumer within 2 hours of the request.
4. In urgent (but not emergent) situations, a provider must schedule an appointment for the consumer with an appropriate service provider. The appointment must be scheduled to occur within 48 hours of screening.
5. In routine situations, provider shall schedule an appointment for the consumer with an appropriate service provider. The appointment must be scheduled to occur within 4 business days.
6. Provider shall assure consumers are provided adequate information regarding all potential providers and the fair and equitable opportunity to make a choice regarding providers as choice is available.
7. This service is designed to be completed within 1 day.

B. Staffing Requirements

1. The phone line must be answered 24 hours/7 days a week by staff trained in crisis management, screening, referral protocols, admission criteria and available resources.
2. An MHP, SAP, or SAM must be available 24 hours/7 days a week to provide consultation to staff providing this service.
3. In order for a referral decision to be made for psychiatric hospitalization or to a Crisis Stabilization Program, a MHP or SAM must review and approve the referral.
4. In order for a referral decision to be made for residential or inpatient detoxification, a MHP or SAM must review and approve the referral.

C. Clinical Operations

D. Service Access

E. Additional Medicaid Requirements

1. Not applicable. Not a Medicaid billable service, unless a basic screening transitions into the gathering of assessment information, then Diagnostic Assessment may be billed in accordance with that definition.

F. Reporting Requirements

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1. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.

SUPPORTED EMPLOYMENT

Definition of Service (Beginning July 1, 2005): In line with current best practice, this service emphasizes that a rapid job search and placement approach be prioritized above traditional prevocational training or traditional vocational rehabilitation. Job development, placement and training are for people who, due to the severity of their disabilities, need support to locate, choose, obtain, learn and maintain a job. Services include supports to choose and obtain paid employment in competitive wage, individual-based community jobs, as well as brief training support to learn the specific job skills/tasks necessary to perform and retain a particular job. Services are provided to any individual interested in obtaining employment, regardless of the degree of disability, and with particular attention and consideration to the individual's interests, strengths, needs, capabilities, priorities, concerns, previous work experiences and informed choice **(i.e. job placement should be individualized).**

Once a job is obtained, brief on-the-job training and support is available through this service to assist individuals in learning the job-specific skills/tasks necessary to successfully performing the new job.

It is expected that service staff will maintain regular, meaningful collaboration with the individual's mental health/substance abuse treatment team.

Services may be provided in a variety of settings and must meet the following specific service criteria:

1) Employment is paid;
2) Employment provides opportunities to interact with people who do not have disabilities;
3) Training includes brief teaching/modeling of the specific skills/tasks necessary to perform the job; and
4) Regular, meaningful collaboration with the mental health/substance abuse treatment team is maintained.

Moreover, the service should maintain a focus on the individual's long-term career goals if a career is important to the individual, and attempt to place the individual in a job accordingly, rather than simply placing the individual in the easiest, lowest requirement job available.. Jobs may be full or part time, and frequent opportunities for individuals to interact with non-disabled co-workers during the performance of their jobs or during breaks, working hour meals or travel to and from work is an important benefit. More than one individual consumer with a disability could work for the same employer and still be considered to receive this service, as long as consumers are not grouped within the work site. Wages must be paid in compliance with all applicable Department of Labor requirements.

The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services. Practitioners providing this service

are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Definition of Service (Beginning July 1, 2006): Job development, placement and training are for people who, due to the severity of their disabilities, need support to locate, obtain and/or learn a job. Services include supports to choose and obtain paid employment in competitive wage, individual-based community jobs, as well as brief training support to learn the specific job skills/tasks necessary to perform and retain a particular job. Services are provided to any individual interested in obtaining employment, regardless of the degree of disability, and with particular attention and consideration to the individual's interests, strengths, needs, capabilities, priorities, concerns, previous work experiences and informed choice **(i.e. job placement should be individualized)**. In line with current best practice, this service emphasizes that a rapid job search and placement approach be utilized.

Once a job is obtained, brief on-the-job training is available through this service to assist individuals in learning the job-specific skills/tasks necessary to successfully performing the new job. Prevocational training and longer-term support to the individual once a job has been obtained should be conducted through the individual's enrollment in Community Support-Individual services, Peer Supports and/or Psychosocial Rehabilitation services.*

It is expected that service staff will maintain regular, meaningful collaboration with the individual's mental health/substance abuse treatment team.

Services may be provided in a variety of settings and must meet the following specific service criteria:

1) Employment is paid;
2) Employment provides opportunities to interact with people who do not have disabilities;
3) Training includes brief teaching/modeling of the specific skills/tasks necessary to perform the job; and
4) Regular, meaningful collaboration with the mental health/substance abuse treatment team is maintained.

Moreover, the service should maintain a focus on the individual's long term career goals if a career is important to the individual, and attempt to place the individual in a job accordingly, rather than simply placing the individual in the easiest, lowest requirement job available. Jobs may be full or part time, and frequent opportunities for individuals to interact with non-disabled co-workers during the performance of their jobs or during breaks, working hour meals or travel to and from work is an important benefit. More than one individual consumer with a disability could work for the same employer and still be considered to receive this service, as long as consumers are not grouped within the work site.

*** NOTE**: In FY06, providers offering this service **only** may continue to include prevocational supports and ongoing job supports to consumers. Beginning FY07, prevocational and any ongoing supports should be provided in accordance with the written definition above.

Target Population	Adults and Adolescents with a: Mental Illness Substance Related Disorder Co-Occurring Substance-Related Disorder and Mental Illness, Co-Occurring Mental Illness and Mental Retardation/Developmental Disabilities Co-Occurring Substance-Related Disorder and Mental Retardation/Developmental Disabilities
Initial Authorization	180 days
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 471 – Community Based Employment Services - Individual — 06 – Work Activity
UAS: **Budget and Expense Categories**	Employment Services Provider 139 – Adult Mental Health 239 – C&A Mental Health 739 – Adult Addictive Diseases 839 – C&A Addictive Diseases
Medicaid:	None
Admission Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; **and** 2. Individuals for whom behavioral health issues have caused unemployment or underemployment.
Continuing Stay Criteria	1. Individuals who meet the target population criteria and indicate an interest through Recovery Planning in establishing or enhancing work skills; **and** 2. Individuals for whom behavioral health issues have caused unemployment or underemployment; **and** 3. Individual demonstrates documented progress relative to goals identified in the Individualized Recovery/Resiliency Plan for employment, but employment goals have not yet been achieved.
Discharge Criteria	1. Goals of the Individualized Recovery/Resiliency Plan related to employment have been substantially met; **or** 2. Individual requests a discharge from this support.
Service Exclusions	
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of a psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder.

Additional Service Criteria:

A. Required Components

1. The programmatic goals of this service must be clearly articulated by the provider, utilizing best/evidence based practices for employment services.
2. Wages must be paid in compliance with all applicable Department of Labor requirements.

B. Staffing Requirements

1. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

C. Clinical Operations

1. Individuals should be encouraged to be as involved and self-directed in the job location and placement process as possible (e.g. the individual should call a potential employer to inquire about a job rather than staff calling when possible (which may entail coaching the individual), and the individual should be offered assistance—though not advice--from staff in making the personal decision about whether or not to disclose his or her disability to a potential employer).

D. Service Access

E. Additional Medicaid Requirements

1. Not Applicable. Not a Medicaid-billable service.

F. Reporting Requirements

1. All applicable MHMRIS and other DMHDDAD reporting requirements must be adhered to.
2. A monthly standardized report may be required by the DMHDDAD to monitor outcomes.

Mental Health and Addictive Disease Services for Adults

ASSERTIVE COMMUNITY TREATMENT - ADULTS

Definition of Service: ACT is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in public hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, and rehabilitative crisis, treatment and community support interventions/services that are available 24-hours/7 days a week. The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence based practices for service delivery and support that have the capacity to adequately address co-occurring disorders/issues if needed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices for ACT. Services are directed towards the identified individual consumer and his or her behavioral health care needs based upon the Individualized Recovery Plan and, based on the needs of the individual, may include (in addition to those services provided by other systems):

1. Assistance to the individual in the development of the Individualized Recovery Plan (IRP);
2. Psychoeducational and instrumental support to individuals and their families;
3. Crisis assessment, support and intervention; and
4. Individualized interventions, which may include:
    a. Identification, with the consumer, of barriers that impede the development of skills necessary for independent functioning in the community as well as strengths which may aid the individual in recovery;
    b. Support to facilitate recovery (including emotional/therapeutic support/assistance with defining what recovery means to the individual in order to assist individual with recovery-based goal setting and attainment);
    c. Service and resource coordination to assist the individual in gaining access to necessary rehabilitative, medical and other services;
    d. Family counseling/training for individuals and their families (as related to the person's IRP);
    e. Assistance in the acquisition of symptom monitoring and illness self-management skills in order to identify and minimize the negative effects of symptoms which interfere with the individual's daily living (may include medication administration and/or observation and assistance with self- medication motivation and skills);
    f. Assistance with financial management skill development;
    g. Assistance with personal development and school/work performance;
    h. Substance abuse counseling and intervention (e.g. motivational interviewing, stage based interventions, refusal skill development, cognitive behavioral therapy, psychoeducational approaches, instrumental support such as helping individual relocate away from friends/neighbors who influence drug use, relapse prevention planning and techniques etc);
    i. Individualized, restorative one-to-one psychosocial rehabilitation and skill development, including assistance in the development of interpersonal/social and

community coping and functional skills (i.e. adaptation/functioning in home, school and work environments);

j. Psychotherapeutic techniques involving the in depth exploration and treatment of interpersonal and intrapersonal issues; and
k. Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.

Individuals receiving this intensive level of community support are expected to experience increased community tenure and decreased frequency and/or duration of hospitalization/crisis services. Through individualized, team-based supports, it is expected that individuals will achieve housing stability, decreased symptomatology (or a decrease in the debilitating effects of symptoms), decreased medication side effects, improved social integration and functioning, and increased movement toward self-defined recovery.

Target Population	Adults with Serious and Persistent Mental Illness, Adult with Co-Occurring Substance Related Disorders and Serious and Persistent Mental Illness Adults with Co-Occurring Serious and Persistent Mental Illness and MR/DD
Initial Authorization	480 units (unit = 15 minutes)
Re-Authorization	Continued Stay Review is required quarterly.
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit: 318 – Assertive Community Treatment (ACT) Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	Intensive Treatment Services Provider 152 – Adult Mental Health
Medicaid:	Mental Health Y3031 – Assertive Community Treatment
Admission Criteria	1. Individuals with severe and persistent mental illness that seriously impairs the ability to live in the community. Priority is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder, because these illnesses more often cause long-term psychiatric disability; **and** 2. Individuals with significant functional impairments as demonstrated by the **inability to consistently engage in at least two of the following:** a. Maintaining personal hygiene; b. meeting nutritional needs; c. caring for personal business affairs; d. obtaining medical, legal, and housing services;

	e. recognizing and avoiding common dangers or hazards to self and possessions; f. persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or other relatives; g. Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities); h. Maintaining a safe living situation (e.g., repeated evictions or loss of housing); **and** 3. Individuals with **one or more of the following problems** that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month): a. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., 3 or more admission per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services. b. Persistent, recurrent, severe, or major symptoms (e.g., affective, psychotic, suicidal). c. Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse (ASAM Levels I, II.1, II.5, III.3, III.5). d. High risk or a recent history of criminal justice involvement (e.g., arrest and incarceration). e. Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless. f. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available. g. Inability to participate in traditional clinic-based services; **and** 4. A lower level of service/support has been tried or considered and found inappropriate at this time.
Continuing Stay Criteria	1. Individuals meet the requirements above; **and** 2. Continued inability to participate in traditional office setting or community setting at a less intense level of service/supports; **and** 3. Substandard housing, homeless, or at imminent risk of becoming homeless related to the behavioral health issues.

Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual no longer meets admission criteria; **or** 3. Goals of the Individualized Recovery Plan have been substantially met; **or** 4. Individual requests discharge and is not in imminent danger of harm to self or others, **or** 5. Transfer to another service/level of care is warranted by a change in individual's condition, **or** 6. Individual requires services not available in this level of care.
Service Exclusions	ACT is a comprehensive team intervention and most services are excluded. Peer Supports, Group Training/Counseling, and Diagnostic/Functional Assessment are the exceptions. On an individual basis, a limited amount of services can be provided to ACT consumers to allow an individual to transition to and from ACT and other community services (e.g., Psychosocial Rehabilitation, Community Supports Team & Individual). The transition plan must be adequately documented in the Individualized Recovery Plan and clinical record. Those receiving Medicaid MR Waivers are excluded from the service.
Clinical Exclusions	Individuals with the following conditions are excluded from admission unless there is clearly documented evidence of psychiatric condition overlaying the primary diagnosis: mental retardation, autism, organic mental disorder, substance related disorder.

Additional Service Criteria:

A. Required Components

1. Assertive Community Treatment must include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings by a mobile multidisciplinary team. The team must provide community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings. Team meetings must be held a minimum of 3 times a week.
2. Services and interventions must be highly individualized and tailored to the needs and preferences of the individual with the goal of maximizing independence and supporting recovery. At lease 60% of all services must involve face-to-face contact with consumers. At least 80% of face-to-face services must be provided in locations other than the office (including the individual's home, based on individual need and preference and clinical appropriateness.
3. It is recommended that the ACT Team provide at least 3 face-to-face contacts per week for most individuals on an ongoing basis, and all individuals participating in ACT must receive a minimum of 4 face-to-face contacts per month. The Team must see each individual once a month for the purpose of symptom assessment/management and management of medications.

4. Service may be delivered by a single team member to 2 ACT consumers at the same time if their goals are compatible, however, this cannot be a standard practice. Services cannot be offered to more than 2 individuals at a time (exception: Item A.5.).
5. The only scenario in which this service may be offered to more than 2 people is when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT). For this to be allowable, there must be an identified cohort of ACT participants whose clinical needs and recovery goals justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than 8 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as ACT. This may be offered no more than 2 hours in any given week. (Effective April 2004 through June 2005).
6. ACT recipients can receive limited Group Training/Counseling (up to 8 units/week) when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy (DBT). For this to be allowable, the ACT participants must have clinical needs and recovery goals which justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than 8 ACT participants at one time and must be directed by no fewer than 2 staff in order to be billed as Group Training/Counseling. This may be offered for no more than 2 hours in any given week (Effective June 2005). Only ACT consumers are permitted to attend these group services.

B. Staffing Requirements

1. Minimum staffing requirements for Assertive Community Treatment include the following positions:
    - A fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be a Mental Health Professional. The Team Leader who is a registered nurse must hold a four-year degree (BSN).
    - A Psychiatrist on a full-time or part-time basis. The psychiatrist must provide clinical and crisis services to all team consumers, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment.
    - One fulltime equivalent Registered Nurse who must provide nursing services for all team consumers and who must work with the team to monitor each individual's clinical status and response to treatment.
    - One-half to one fulltime equivalent Substance Abuse Professional who must work on a fulltime or half-time basis to provide or access substance abuse supports for team consumers.
    - A clinically trained practitioner who is either a Mental Health Professional or a Licensed Clinician and who must provide individual and group support to team consumers (this position is in addition to the Team Leader).
    - One certified Peer Specialist who provides rehabilitation and recovery support functions

- One to three paraprofessionals (or professionals) who must provide services under the supervision of a Licensed Clinician; one of these staff must be a Vocational Rehabilitation Specialist.

2. The Substance Abuse Professional, Mental Health Professional, Peer Support Specialist, and the paraprofessionals function as primary practitioners for a caseload of consumers. The Team Leader, Registered Nurse, and Vocational Rehabilitation Specialist function as primary practitioners for a partial caseload of consumers and provide support to all team recipients.
3. The ACT team maintains a small consumer-to-clinician ratio, of no more than 12 consumers per staff member. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served.
4. Documentation must demonstrate that all team members are engaged in the support of each consumer served by the team (excluding the SAP if substance related issues have been ruled out).

C. Clinical Operations

1. ACT Teams must be designed to deliver services in various environments, such as homes, schools, jails, homeless shelters, and street locations. The provider should keep in mind that individuals may prefer to meet staff at a community location other than their homes or other conspicuous locations (e.g. their place of employment or school), especially if staff drive a vehicle that is clearly marked as a state or agency vehicle, or if staff must identify themselves and their purpose to gain access to the individual in a way that may potentially embarrass the individual or breech the individual's privacy/confidentiality. Staff should be sensitive to and respectful of individuals' privacy/confidentiality rights and preferences in this regard to the greatest extent possible (e.g. if staff must meet with an individual during their work time, mutually agree upon a meeting place nearby that is the least conspicuous from the individual's point of view).
2. The organization must have policies that govern the provision of services in natural settings and can document that it respects consumers' and/or families' right to privacy and confidentiality when services are provided in those settings.
3. Each ACT Team provider must have policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
4. The organization must have established procedures/protocols for handling emergency and crisis situations that describe methods for handling individuals who require psychiatric hospitalization.
5. The organization must have an Assertive Community Treatment Organizational Plan that the following descriptions:
    - Particular rehabilitation, recovery and case management models utilized, types of intervention practiced, and typical daily schedule for staff
    - Staffing pattern and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated

- Hours of operation, the staff assigned, and types of services provided to consumers, families, and/or guardians
- How the plan for services is modified or adjusted to meet the needs specified in the Individualized Recovery Plan
- Inter-team communication plan regarding consumer support (e.g., e-mail, team staffings, staff safety plan such as check-in protocols etc.)

D. Service Accessibility

1. Services must be available 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services.
2. The team must be able to rapidly respond to early signs of relapse and decompensation and must have the capability of providing multiple contacts daily to individuals in acute need.
3. On-call coverage must be provided by an ACT staff member skilled in crisis intervention.
4. There must be documented evidence that service hours of operation include evening, weekend and holiday hours.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

MENTAL HEALTH INTENSIVE DAY TREATMENT - ADULTS

Definition of Service: Provides for the stabilization of psychiatric impairments with time limited, intensive, clinical services provided by a multi-disciplinary team in a clinic or facility-based setting available at least 5 days per week. This service includes the capacity for the administration of medication as necessary for an individual. Candidates for these services have adequate natural/community support systems and do not have behavioral health issues that are imminently dangerous. Services include physician and nursing services available onsite on a daily basis. Mandatory services include medical services, family contact, group counseling/training, nursing services, medical management and continuing care planning. Other available services include family counseling, individual counseling, and education/training as it pertains to the alleviation of identified behavioral health problems. Treatment is based on the needs and goals of the individual as articulated in the Individualized Recovery Plan. This service may be offered for a maximum of 5 hours per day.

The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence based practices for service delivery and support that are based on the population(s) and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices for adult intensive day treatment programs.

Target Population	Adults with Serious and Persistent Mental Illness Adults with Serious and Persistent Mental Illness and a Co-occurring Substance Related Disorder
Initial Authorization	75 units (unit = 1 hour) (21 days)
Re-Authorization	75 units (unit = 1 hour) (21 days)
MHMRIS: **Subunit & Modality**	Subunit: 331 – Intensive Day Treatment (Partial Hospitalization) Modality: 07 – Day Patient
UAS: **Budget and Expense Categories**	MH Intensive Day Treatment Services Provider 159 – Adult Mental Health
Medicaid:	Mental Health Y3001 – Intensive Day Treatment (Partial Hospitalization)

Admission Criteria	1. Individual must have primary behavioral health issues that may need medical and treatment services to decrease risk factors including suicidal and/or homicidal ideation or aggressive behavior; or all of the following: 2. Presence of frequent or severe symptoms such as psychosis, mood disorders (e.g., depression, severe withdrawal), anxiety, and addiction (e.g. alcohol, drug use) that require medical stabilization; and 3. Community supports are sufficient to allow participation in the program versus a higher intensity service; and 4. Level of functioning precludes provision of services in less restrictive service (active symptoms disruptive to others); and 5. Reasonable expectation that the individual can improve demonstrably within 7 – 21 days.
Continuing Stay Criteria	1. Primary behavioral health issues that continue to present a risk or danger to themselves or others including suicidal and/or homicidal ideation or aggressive behavior; or 2. Continued presence of frequent or severe symptoms such as psychosis, mood disorders (e.g., depression, severe withdrawal), anxiety and addiction (e.g., alcohol, drug use) that require medical stabilization; or 3. Ongoing need for psychiatric stabilization that includes the need for nursing/physician participation.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Psychiatric symptoms are stabilized; **or** 3. Medication is titrated so that there is no longer a need for daily nursing oversight; **or** 4. The individual no longer presents significant risk factors; or 5. The consumer/family requests discharge from services and individual is not in imminent danger of harm to self or others; or 6. The consumer/family requests services not available through this milieu; **or** 7. Individual is able to participate in recovery or rehabilitation planning and services, and is not in imminent danger of harm to self or others; **or** 8. Individual has a better awareness of illness/symptoms and medications and is knowledgeable of ways to manage symptoms and is not in imminent danger of harm to self or others.
Service Exclusions	Not offered in conjunction with ACT, SA Adult Day Services, Medication Administration, Physician Assessment, Nursing Assessment, Individual, Group, and Family Counseling, Psychosocial Rehabilitation, and Crisis Stabilization Programs.

Clinical Exclusions	1. Level of functioning precludes more intensive interventions. 2. Individuals who require one-to-one supervision for protection of self or others (e.g. inpatient psychiatric care or crisis residential services) 3. Unless clearly documented evidence of an acute psychiatric episode, primary diagnosis of Substance Abuse, Developmental Disability or of delirium, dementia, autism or organic mental disorder. 4. Legal status requiring a locked facility.

Additional Service Criteria:

A. Required Components

1. The service must operate at an established clinic site.
2. This service is distinguished by the need for the level of medical support, which, if not present for the individual served, would indicate a lesser level of service.
3. Face-to-face RN services must be available daily as indicated below.
4. Face-to-face Physician services must be available as required to meet supervision and clinical operations requirements indicated below.
5. The service must be able to handle crises situations of a psychiatric and/or medical nature to the extent that individuals and staff are safe from harm.

B. Staffing Requirements

1. The program must be under the supervision of a Physician.
2. Services must be provided and/or activities led by staff who are:
   - a Registered Nurse (RN)
   - a Mental Health Professional (MHP)
   - a Social Services Technician (SST) II or above under the supervision of an MHP. An SST II is someone who has a high school diploma plus 90 hours of college credits (at least 15 of which are in psychology, social work, or related human services fields) and 3 years experience in a social services setting OR has a bachelors degree plus 1 year experience in a social services setting OR
   - a Peer Specialist under the supervision of an MHP.
3. There must be an RN or MHP present face-to-face at all times the service is in operation, regardless of the number of consumers participating.
4. The maximum face-to-face ratio cannot be more than 20 consumers to 1 MHP or RN based on average daily attendance.
5. The maximum face-to-face ratio cannot be more than 8 consumers to 1 direct service/program staff, based on average daily. MHPs are included in the staff count for purposes of calculating this ratio.
6. Nursing services must be available daily, but are not counted for staff to consumer ratios unless the RN is available face-to-face during the entire operation of the service.

7. All staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.
8. An RN or Physician must be available at the site or program facility and able to be face-to-face within 15 minutes of a request for assistance (rapid response).
9. An RN or Physician may be shared with other programs as long as they are available as required for supervision, clinical operations, and rapid response, and as long as they are not counted in consumer to staff ratios in 2 different programs operating at the same time.

C. Clinical Operations

1. This service must operate within an established clinic site approved to bill Medicaid for services.
2. This service may operate in the same building as other services, however, there must be a distinct separation between services in staffing (except as provided above for RN and Physician), program description, and physical space.
3. Every admission must be documented.
4. A Physician's participation in support of the individual must be documented at least 3 times per week, at least 2 of which must be face-to-face. Every physician contact including medication prescription and administration must be documented.
5. An RN's progress note showing participation in support of the consumer must be documented at least daily for the first 7 days and at least 2 times in each subsequent 7-day period. Every nursing contact, including medication administration must be documented.
6. In addition to other documentation requirements, a daily progress note must be written for each consumer by some member of the direct service/program staff.
7. A weekly summary and signoff on supervised staff's notes must be documented by the supervising MHP.
8. Daily attendance of each individual participating in the program must be documented showing number of hours in attendance for billing purposes.
9. Transition planning for less intensive service options must begin at the onset of this service delivery and the clinical record must document this planning and the activities undertaken to support the transitional process.
10. When this service is used to transition an individual from 24-hour intensive supports, documentation must demonstrate careful planning to maximize the effectiveness of this service and the activities undertaken to support the transitional process.
11. The program must have an Intensive Day Treatment Organizational Plan that includes the following information:
    - Program's clinical philosophy
    - Hours of operation, the staff assigned, and the types of services and activities provided for both consumers and families
    - How individuals are involved in treatment planning and services
    - How the plan for services will be modified or adjusted to meet the needs specified in each Individualized Services Plan
    - How the individual's and family's requests for discharge and change in services or service intensity are handled.

D. Service Access

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

PSYCHOSOCIAL REHABILITATION - ADULTS

Definition of Service: A therapeutic, rehabilitative, skill building and recovery promoting service for individuals to gain the skills necessary to allow them to remain in or return to naturally occurring community settings and activities. Services include, but are not limited to:

1) Individual or group skill building activities that focus on the development of skills to be used by individuals in their living, learning, social and working environments,
2) Social, problem solving and coping skill development;
3) Illness and medication self-management;
4) Prevocational skills (for example: preparing for the workday; appropriate work attire and personal presentation including hygiene and use of personal effects such as makeup, jewelry, perfume/cologne etc as appropriate to the work environment; time management; prioritizing tasks; taking direction from supervisors; appropriate use of break times and sick/personal leave; importance of learning and following the policies/rules and procedures of the workplace; workplace safety; problem solving/conflict resolution in the workplace; communication and relationships with coworkers and supervisors; resume and job application development; on-task behavior and task completion skills such as avoiding distraction from work tasks, following a task through to completion, asking for help when needed, making sure deadlines are clarified and adhered to, etc; learning common work tasks or daily living tasks likely to be utilized in the workplace such as telephone skills, food preparation, organizing/filing, scheduling/participating in/leading meetings, computer skills etc) and
5) Recreational activities/leisure skills that improve self-esteem and recovery.

The programmatic goals of the service must be clearly articulated by the provider, utilizing a best/evidence based model for service delivery and support. These best/evidence based models may include: the Boston University Psychosocial Rehabilitation approach, the Lieberman Model, the International Center for Clubhouse Development approach, or blended models/approaches in accordance with current psychosocial rehabilitation research. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based models and practices for psychosocial rehabilitation.

This service is offered in a group setting, though limited, non-routine one-to-one interventions are allowable within the service when more circumstantially appropriate. Group activities and interventions should be made directly relevant to the needs, desires and IRP goals of the individual participants (i.e. an additional activity/group should be made available as an alternative to a particular group for those individuals who do not need or wish to be in that group, as clinically appropriate).

This service may be provided as a step-down from intensive day treatment. Services must be provided in a clinic or other facility-based setting, and available at least 25 hours per week. This service is offered for a maximum of 5 hours per day.

Target Population	Adults with Serious Mental Illness Adults with a -Co-Occurring Serious Mental Illness and Substance Related Disorder Adults with a Serious Mental Illness and CO-Occurring MR/DD
Initial Authorization	180 days (unit=1 hour)
Re-Authorization	180 days
Authorization Period	180 days
MHMRIS: **Subunit & Modality**	Subunit — Modality 333 – Psychosocial Rehabilitation — 07 – Day Patient
UAS: **Budget and Expense Categories**	Psychosocial Rehabilitation Services Provider 155 – Adult Mental Health
Medicaid:	Mental Health Y3032 – Psychosocial Rehabilitation
Admission Criteria	1. Individual must have primary behavioral health issues (including those with a co-occurring substance abuse disorder or MR/DD) and present a low or no risk of danger to themselves or others; **and one or more of the following:** 2. Individual is not functional in essential life skills such as daily living, social skills, vocational/academic skills and/or community/family integration; **or** 3. Individual needs frequent assistance to obtain and use community resources.
Continuing Stay Criteria	1. Primary behavioral health issues that continue to present a low or no imminent risk of danger to themselves or others (or is at risk of moderate to severe symptoms); **and one or more of the following:** 2. Individual improvement in skills in some but not all areas; **or** 3. If services are discontinued there would be an increase in symptoms and decrease in functioning; **or** 4. Increase needed in use of community supports with additional supports and skills training or length of time participating at this level is not significant enough to identify change in skill or community resource utilization.
Discharge Criteria	1. An adequate continuing care plan has been established; **and one or more of the following:** 2. Individual has acquired a significant number of needed skills; **or** 3. Individual has sufficient knowledge and use of community supports; **or** 4. Individual demonstrates ability to act on goals and is self sufficient or able to use peer supports for attainment of self sufficiency; **or** 5. Consumer/family need a different level of care; **or** 6. Consumer/family requests discharge.

Service Exclusions	1. Cannot be offered in conjunction with SA Day Services. 2. Service can be offered while enrolled in a Crisis Stabilization Program in a limited manner when documentation supports this combination as a specific need of the individual. Time and intensity of services in PSR must be at appropriate levels when PSR is provided in conjunction with other services. (This will trigger a review by the External Review Organization). This service cannot be offered in conjunction with Medicaid MR Waiver services.
Clinical Exclusions	1. Individuals who require one-to-one supervision for protection of self or others. 2. Individual has primary diagnosis of substance abuse, developmental disability, autism, or organic mental disorder without a co-occurring DSM IV mental disorder diagnosis. 3. Legal status requiring a locked facility.

Additional Service Criteria:

A. Required Components

1. This service must operate at an established site approved to bill Medicaid for services. However, individual or group activities should take place offsite in natural community settings as is appropriate to the participating consumer's Individualized Recovery Plan.
2. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the PSR program is in operation except as described above.
3. Adequate space, equipment, furnishings, supplies and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for consumer use within the PSR program must not be substantially different from that provided for other uses for similar numbers of individuals.
4. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.
5. A PSR program must operate to assist individuals in attaining, maintaining, and utilizing the skills and resources needed to aid in their own rehabilitation and recovery.

B. Staffing Requirements

1. The program must be under the clinical supervision of a Mental Health Professional (MHP) who is credentialed as a Registered Psychosocial Rehabilitation Professional (RPRP), a Certified Psychosocial Rehabilitation Professional (CPRP)[2], or staff who can demonstrate activity toward attainment of certification.

[2] NOTE: The International Association of Psychosocial Rehabilitation Services (IAPSRS) has changed its registration of professionals from APRP and RPRP to CPRP. This process will allow currently registered individuals until June 30, 2005 to complete the training and testing

2. Services must be provided and/or activities led by staff who are one of the following:
    - an MHP
    - a Substance Abuse Manager (SAM)
    - a Peer Specialist, CPRP, or Paraprofessional under the supervision of an MHP or SAM.
3. There must be an MHP present face-to-face at least 50% of all times the service is in operation up to 20 hours per week, regardless of the number of consumers participating.
4. The maximum face-to-face ratio cannot be more than 12 consumers to 1 direct service/program staff (including RPRPs and CPRPS) based on average daily attendance of consumers in the program.
5. At least one CPRP (or someone demonstrating activity toward attainment of certification) must be onsite face-to-face at all times (either the supervising MHP or other CPRP staff) while the program is in operation, regardless of the number of consumers participating. All staff are encouraged to seek and obtain the CPRP credential. All staff must have an understanding of recovery and psychosocial rehabilitation principles as published by IAPSRS and must possess the skills and ability to assist individuals in their own recovery processes.
6. Basic knowledge necessary for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
7. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
8. If the program does not employ someone who meets the criteria for a SAM, then the program must have documentation of access to an addictionologist and/or SAM for consultation on addiction-related disorders as co-occurring with the identified mental illness.
9. An MHP or SAM may be shared with other programs as long as these professionals are available as required for supervision and clinical operations and as long as they are not counted in consumer to staff ratios for two different programs operating at the same time.

C. Clinical Operations

1. Rehabilitation services facilitate the development of an individual's skills in the living, learning, social, and working environments, including the ability to make decisions regarding: self-care, management of illness, life work, and community participation. The services promote the use of resources to integrate the individual into the community.

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required for the new certification as a CPRP. After that date, the APRP and RPRP registration will end. Professionals seeking certification for the first time are required to follow the CPRP certification requirements.

2. Rehabilitation services are consumer driven and are founded on the principles and values of individual choice and active involvement of individuals in their rehabilitation. Through the provision of both formal and informal structures consumers are able to influence and shape service development.
3. Rehabilitation services must include education on self-management of symptoms, medications and side effects; identification of rehabilitation preferences; setting rehabilitation goals; and skills teaching and development.
4. All individuals should participate in setting individualized goals for themselves and in assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
5. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated goals.
6. PSR programs must offer a range of skill-building and recovery activities from which individuals choose those that will most effectively support achievement of the individual's rehabilitation and recovery goals. These activities must be developed based on participating individual's input and stated interests. Some of these activities should be taught or led by consumers themselves as part of their recovery process.
7. A PSR program must be capable of serving individuals with co-occurring disorders of mental illness and substance abuse utilizing integrated methods and approaches that address both disorders at the same time (e.g. groups and occasional individual interventions utilizing approaches to co-occurring disorders such as motivational interviewing/building motivation to reduce or stop substance use, stage based interventions, refusal skill development, cognitive behavioral techniques, psychoeducational approaches, relapse prevention planning and techniques etc). For those individuals whose substance abuse and dependence makes it difficult to benefit from the PSR program, even with additional or modified methods and approaches, the PSR program must offer co-occurring enhanced services or make appropriate referrals to specialty programs specifically designed for such individuals.
8. The program must have a PSR Organizational Plan addressing the following:
    a. Philosophical principles of the program must be actively incorporated into all services and activities including[3]:
        i. View each individual as the director of his/her rehabilitation process
        ii. Solicit and incorporate the preferences of the individuals served
        iii. Believe in the value of self-help and facilitate an empowerment process
        iv. Share information about mental illness and teach the skills to manage it
        v. Facilitate the development of recreational pursuits
        vi. Value the ability of each individual with a mental illness to seek and sustain employment and other meaningful activities in a natural community environment
        vii. Help each individual to choose, get, and keep a job (or other meaningful daily activity)
        viii. Foster healthy interdependence

[3] Adapted from Best Practices in Psychosocial Rehabilitation, edited by Hughes and Weinstein.

ix. Be able to facilitate the use of naturally occurring resources to replace the resources of the mental health system.

b. Services and activities described must include attention to the following:
   i. Engagement with others and with community
   ii. Encouragement
   iii. Empowerment
   iv. Consumer Education and Training
   v. Family Member Education and Training
   vi. Assessment
   vii. Financial Counseling
   viii. Program Planning
   ix. Relationship Development
   x. Teaching
   xi. Monitoring
   xii. Enhancement of vocational readiness
   xiii. Coordination of Services
   xiv. Accommodations
   xv. Transportation
   xvi. Stabilization of Living Situation
   xvii. Managing Crises
   xviii. Social Life
   xix. Career Mobility
   xx. Job Loss
   xxi. Vocational Independence
c. A description of the particular rehabilitation models utilized, types of interventions practiced, and typical daily activities and schedule.
d. A description of the staffing pattern, plans for staff who will achieve CPRP credentials, and how staff are deployed to assure that the required staff-to-consumer ratios are maintained, including how unplanned staff absences, illnesses, and emergencies are accommodated.
e. A description of how the program will assure that it is co-occurring capable and how it will adjust or make appropriate referrals for individuals needing a co-occurring enhanced PSR program.
f. A description of the hours of operation, the staff assigned, and the types of services and activities provided for consumers, families, parents, and/or guardians including how consumers are involved in decision-making about both individual and program-wide activities.
g. A description of how the plan for services and activities will be modified or adjusted to meet the needs specified in each IRP.
h. A description of services and activities offered for education and support of family members.
i. A description of how consumer requests for discharge and change in services or service intensity are handled and resolved.

D. Service Access

1. A PSR program must be operated for no less than 25 hours a week, typically during day, evening and weekend hours. No more than 5 hours per day may be billed for any one consumer.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Weekly progress notes must document the individual's progress relative to functioning and skills related to goals identified in his/her IRP.
2. Daily attendance of each consumer participating in the program must be documented showing the number of hours in attendance for billing purposes.
3. When this service is used in conjunction with Crisis Stabilization Programs, Peer Supports, and ACT (on a limited basis), documentation must demonstrate careful planning to maximize the effectiveness of this service as well as appropriate reduction in service amounts of PSR. Utilization of psychosocial rehabilitation in conjunction with these services is subject to review by the External Review Organization.

SUBSTANCE ABUSE DAY TREATMENT - Adults

Definition of Service: A time limited, multi-faceted approach treatment service for persons who require structure and support to achieve and sustain recovery from substance related disorders. These services are available during the day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school and to be a part of their family life. The following types of services may be included:

1) Didactic presentations/ psychoeducational approaches;
2) Individual counseling;
3) Group counseling;
4) Family counseling and family didactic/psychoeducational approaches (as appropriate); and
5) Regular urine drug screenings.

This service should be scheduled and available at least 5 hours per day, 4 days per week, with no more than two consecutive days without service availability for high need individuals (ASAM Level II.5). There should be at least 3 hours of scheduled services available per day, 3 days per week with no more than two consecutive days without service availability for lower need individuals (ASAM Level II.1). The maximum number of hours that can be billed within one day for any one individual is 5 hours. An Adult Substance Abuse Day Services Program may have variable lengths of stay. It is recommended that individuals attend at a frequency appropriate to their level of need and that each individual's frequency of attendance be reduced as recovery becomes established and the individual becomes able to resume more and more usual life roles and obligations.

Strategies for recovery and relapse prevention should include community and social support systems in the planned interventions. Services are provided according to individual needs and goals as articulated in the Individualized Recovery Plan. The programmatic goals of the service must be clearly articulated by the provider, utilizing best/evidence based practices for service delivery and support that are based on the population(s) and issues to be addressed. These may include Motivational Interviewing/Enhancement, stage-based interventions, refusal skill development, Cognitive Behavioral Therapy, co-occurring disorder approaches, relapse prevention planning and techniques, and others as appropriate to the individual and issues to be addressed. Practitioners providing this service are expected to maintain knowledge and skills regarding current research trends in best/evidence based practices.

Target Population	Adults with Substance Related Disorders, including those with a Co-occurring Mental Illness or Developmental Disability.
Initial Authorization	180 days (unit=1 hour)
Re-Authorization	180 days
Authorization Period	180 days

MHMRIS: **Subunit & Modality**	Subunit — Modality 343 – Substance Abuse Day Services 07 – Day Patient
UAS: **Budget and Expense Categories**	Substance Abuse Day Treatment Provider 756 – Adult Addictive Diseases
Medicaid:	Addictive Diseases Y3026 – Substance Abuse Day Services
Admission Criteria	1. A DSM IV diagnosis of Substance Abuse or Dependence or substance- related disorder with a co-occurring DSM IV diagnosis of mental illness or DD; **and one or more of the following:** 2. The substance use is incapacitating, destabilizing or causing the individual anguish or distress and the individual demonstrates a pattern of alcohol and/or drug use that has resulted in a significant impairment of interpersonal, occupational and/or educational functioning; **or** 3. The individual's substance abuse history after previous treatment indicates that provision of outpatient services alone is not likely to result in the individual's ability to maintain sobriety; **or** 4. The individual is able to function in a community environment even with impairments in social, medical, family, or work functioning; **or** 5. The individual is sufficiently motivated to participate in treatment; **or** 6. There is a reasonable expectation that the individual can improve demonstrably within 3-6 months[2]; **or** 7. The individual is assessed as needing ASAM Level II or III.1; **or** 8. The individual has no significant cognitive and/or intellectual impairments that will prevent participation in and benefit from the services offered and has sufficient cognitive capacity to participate in and benefit from the services offered; **or** 9. The individual is not actively suicidal or homicidal, and the individual's crisis, Intensive Day Treatment, and/or inpatient needs (if any) have been met prior to participation in the program.
Continuing Stay Criteria	1. The individual's condition continues to meet the admission criteria. 2. Progress notes document progress in reducing use and abuse of substances; developing social networks and lifestyle changes; increasing educational, vocational, social and interpersonal skills; understanding addictive disease; and/or establishing a commitment to a recovery and maintenance program, but the overall goals of the treatment plan have not been met. 3. There is a reasonable expectation that the individual can achieve the goals in the necessary time frame.
Discharge Criteria	1. An adequate continuing care or discharge plan is established and

[2] Program serving TANF eligible clients must seek review every 3 months in accordance with TANF policy.

	linkages are in place; **and one or more of the following:** 2. Goals of the Individualized Recovery Plan (IRP) have been substantially met; **or** 3. The individual requests discharge and is not in imminent danger of harm to self or others; **or** 4. Transfer to another level of service is warranted by change in the individual's condition or nonparticipation; **or** 5. The individual refuses to submit to random drug screens; **or** 6. The individual requires services not available at this level.
Service Exclusions	Services cannot be offered with Intensive Day Treatment or Psychosocial Rehabilitation. When offered with ACT or Crisis Residential Services, documentation must indicate efforts to minimize duplication of services and effectively transition the individual to the appropriate services. This combination of services is subject to review by the External Review Organization.

Additional Service Criteria:

A. Required Components

1. This service must be licensed by ORS under the Rules and Regulations for Drug Abuse Treatment Programs, 290-4-2.
2. Substance Abuse Day Services emphasizes reduction in use and abuse of substances and/or continued abstinence; the negative consequences of substance abuse; development of social support network and necessary lifestyle changes; educational skills; vocational skills leading to work activity by reducing substance abuse as a barrier to employment; social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.
3. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e., plans or schedules of days or times of day for certain activities. The program may also utilize group and/or individual counseling and/or therapy.
4. The program utilizes methods, materials, settings, and outside resources appropriate to the developmental and cognitive levels, capabilities, age, and gender of participants.
5. The program utilizes methods, materials, approaches, activities, settings, and outside resources appropriate for and targeted to individuals with co-occurring disorders of mental illness and substance abuse and targeted to individuals with co-occurring developmental disabilities and substance abuse when such individuals are referred to the program.
6. The program conducts random drug screening and uses the results of these tests for marking participant's progress toward goals and for service planning.
7. The program is provided over a period of several weeks or months and often follows detoxification or residential services.
8. This service must operate at an established site approved to bill Medicaid for services. However, limited individual or group activities may take place off-site in natural

community settings as is appropriate to each individual's IRP. Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings offsite may be considered part of these limited individual or group activities for billing purposes only when time limited and only when the purpose of the activity is introduction of the participating individual to available NA and/or AA services, groups or sponsors. NA and AA meetings occurring during the SA Day Services Program may not be counted toward the SA Day Services billable hours for any individual.

9. This service may operate in the same building as other day services, however, there must be a distinct separation between services in staffing, program description, and physical space during the hours the Substance Abuse Day Services is in operation.
10. Adequate space, equipment, furnishings, supplies, and other resources must be provided in order to effectively provide services and so that the program environment is clean and in good repair. Space, equipment, furnishings, supplies, transportation, and other resources for participating individuals' use within the Substance Abuse Day Services program must not be substantially different from that provided for other uses for similar numbers of individuals.

B. Staffing Requirements

1. The program must be under the clinical supervision of a Substance Abuse Manager (SAM) who is onsite a minimum of 50% of the hours the service is in operation.
2. Services must be provided by staff who are:
    - a SAM or
    - a Substance Abuse Professional (SAP) or
    - a Paraprofessional under the supervision of an MHP or SAM
3. All staff must receive training in the use of the Addiction Severity Index (ASI) for assessment, in substance abuse interventions and service technologies, and in the recognition and treatment of co-occurring disorders. All professional staff must complete training in the use of the ASI for assessment.
4. Basic knowledge necessary for all staff serving individuals with mental illness or substance abuse in "co-occurring capable" day services must include the content areas in the Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Day Services Serving Individuals with Co-Occurring Disorders.
5. Programs must have documentation that there is one staff person that is "co-occurring capable." This person's knowledge must go beyond basic understanding and must demonstrate actual staff capabilities in using that knowledge for individuals with co-occurring disorders. Personnel documentation should demonstrate that this staff person has received a minimum of 4 hours of training in co-occurring treatment within the past 2 years.
6. There must be a SAM or a SAP on-site at all times the service is in operation, regardless of the number of individuals participating.
7. The maximum face-to-face ratio cannot be more than 12 individuals to 1 direct service/program staff based on average daily attendance of individuals in the program.
8. The maximum face-to-face ratio cannot be more than 20 individuals to 1 SAP based on average daily attendance of individuals in the program.

9. A physician and a Registered Nurse or a Licensed Practical Nurse with appropriate supervision must be available to the program either by a physician and/or nurse employed by the agency, through a contract with a licensed practitioner, or by written referral or affiliation agreement with another agency or agencies that offer physician and/or nursing services. The physician is responsible for addiction and psychiatric consultation, assessment, and care (including but not limited to ordering medications and/or laboratory testing) as needed. The nurse is responsible for nursing assessments, health screening, medication administration, health education, and other nursing duties as needed.
10. A SAM or SAP may be shared with other programs as long as they are available as required for supervision and clinical operations and as long as their time is appropriately allocated to staffing ratios for each program.

C. Clinical Operations

1. It is expected that the transition planning for less intensive service options will begin at the onset of this service delivery. Documentation must demonstrate this planning.
2. Each individual should participate in setting individualized goals for themselves and in assessing their own skills and resources related to sobriety, use/abuse, and maintaining recovery. Goals are set by exploring strengths and needs in the individual's living, learning, social, and working environments. Implementation of services may take place individually or in groups.
3. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve sobriety and/or reduction in use/abuse and maintenance of recovery.
4. Substance Abuse Day Services programs must offer a range of skill-building and recovery activities within the program, including but not limited to:
    - Psycho-educational activities focusing on the disease of addiction, relapse prevention, and the health consequences of addiction
    - Therapeutic group treatment and counseling
    - Individual support for recovery
    - Individualized treatment and service planning
    - Assessment and reassessment
    - Drug screening/toxicology examinations
    - Leisure and social skill-building activities without the use of substances
    - Family education and engagement
    - Vocational readiness and support
    - Linkage to health care
    - Linkage to natural supports and self-help opportunities
    - Service coordination unless provided through another service provider.
5. In addition to these required activities within the program, the following must be offered as needed either within the program or through referral to/or affiliation with another agency or practitioner, and may be billed in addition to the billing for Substance Abuse Day Services:
    - Community Support – Individual – for housing, legal and other issues
    - Individual counseling in exceptional circumstances for traumatic stress and other mental illnesses for which special skills or licenses are required

- Physician assessment and care
- Psychological testing
- Nursing assessment and health screening.

6. The program must have a Substance Abuse Day Services Organizational Plan addressing the following:
    - The philosophical model of the program and the expected outcomes for program participants (i.e., harm reduction, abstinence, beginning of or maintaining individually defined recovery, employment readiness, relapse prevention, stabilization and treatment of those with co-occurring disorders).
    - The schedule of activities and hours of operations.
    - Staffing patterns for the program.
    - How the activities listed in number 11 above will be offered and/or made available to those individuals who need them, including how that need will be determined.
    - How assessments will be conducted.
    - How staff will be trained in the administration of the ASI, addiction services, and technologies.
    - How staff will be trained in the recognition and treatment of co-occurring disorders of mental illness and substance abuse pursuant to the Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
    - How services for individuals with co-occurring disorders will be flexible and will include services and activities addressing both mental health and substance abuse issues of varying intensities and dosages based on the symptoms, presenting problems, functioning, and capabilities of such individuals.
    - How individuals with co-occurring disorders who cannot be served in the regular program activities will be provided and/or referred for time-limited special integrated services that are co-occurring enhanced as described in the Georgia DMHDDAD Suggested Best Practices: Principles and Staff Capabilities for Serving Adults with Co-Occurring Disorders of Substance Abuse and Mental Illness.
    - How services will be coordinated with the substance abuse array of services including assuring. or arranging for appropriate referrals and transitions.
    - How the requirements in these service guidelines will be met.

D. Service Access

1. The program is offered at least 5 hours per day at least 4 days per week with no more than 2 consecutive days between offered services, and distinguishes between those individuals needing between 9 and 20 hours per week of structured services per week (ASAM Level II.1) and those needing 20 hours or more of structured services per week (ASAM Level II.5 or III.1) in order to begin recovery and learn skills for recovery maintenance. The program may offer services a minimum of only 3 hours per day for only 3 days per week with no more than 2 consecutive days between offered services if only individuals at ASAM Level II.1 are served.

E. Additional Medicaid Requirements

1. Currently, there are no additional Medicaid requirements to be added to the requirements above when billing Medicaid for this service.

F. Reporting Requirements

1. All applicable Medicaid, MHMRIS, and other DMHDDAD reporting requirements must be adhered to.

G. Documentation Requirements

1. Every admission and assessment must be documented.
2. Progress notes must include written daily documentation of important occurrences; level of functioning; acquisition of skills necessary for recovery; progress on goals identified in the IRP including acknowledgement of addiction, progress toward recovery and use/abuse reduction and/or abstinence; use of drug screening results by staff; and evaluation of service effectiveness.
3. Daily attendance of each individual participating in the program must be documented showing the number of hours in attendance for billing purposes.
4. This service may be offered in conjunction with ACT or Crisis Residential Services for a limited time to transition consumers from one service to the more appropriate one. When this service is used in conjunction with ACT or Crisis Residential services, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as an appropriate reduction in service amounts of the service to be discontinued. Utilization of Substance Abuse Day Services in conjunction with these services is subject to review by the External Review Organization.

GEORGIA DMHMRSA – BEST PRACTICE SUGGESTIONS

PRINCIPLES AND STAFF CAPABILITIES FOR DAY SERVICES FOR ADULTS WITH CO-OCCURRING DISORDERS – APRIL 17, 2002

PRINCIPLES

1. Services for persons with co-occurring disorders should be integrated, rather than sequential. That is, they should be structured to deal with both disorders at once rather than requiring one disorder or one set of symptoms to be dealt with before services for the other can begin.
2. Psychosocial Rehabilitation (PSR) programs and Substance Abuse (SA) Day Services programs will be initially encouraged and eventually required to work toward becoming "co-occurring capable," that is, able to deal flexibly with the issues of persons with co-occurring disorders.
3. "Co-occurring enhanced" services are time limited and go beyond co-occurring capable services and programs. They are characterized by the following:
4. Additional or special assessments requiring additional training or competencies, perhaps utilizing additional or specialized assessment tools;
5. Special training, experience, licensure, certification, or other qualifications of staff beyond basic recognition and general capabilities of addressing the needs of persons with co-occurring disorders within a larger program (see recommended staff capabilities below);
6. Availability of addictionologist and/or SAM consultation;
7. Availability of psychiatric consultation and/or medication management;
8. Availability of crisis services if needed, either directly or through an interagency agreement with a mobile crisis service;
9. Additional staff to client ratio beyond the minimum requirements for a limited period of time, in order to deal effectively with individuals needing more intense or more frequent services than those offered in a co-occurring capable day services program; and
10. Additional programming intensity or specialized approaches or activities requiring significant adjustments to the usual day services activities to assure adequate dosing, frequency, and integration of services for individuals with co-occurring disorders.
11. Programs that provide PSR or SA Day Services will be required to either provide or arrange for co-occurring enhanced integrated services for adults with co-occurring disorders until those individuals can move back into regular co-occurring capable day services. Adults with co-occurring disorders should not be expected to simply adapt to usual or routine PSR or SA Day Services activities.
12. Co-occurring enhanced day services may be provided within a larger SA Day Services or PSR program, may be a separate day services program within a larger agency, or may be a stand-alone service provider.
13. An adult with serious and persistent mental illness and a co-occurring substance abuse disorder should be served in a co-occurring capable or co-occurring enhanced PSR program. Adults with substance abuse or dependence who also have a co-occurring mental health

needs that do not rise to the level of serious and persistent mental illness should be served in a co-occurring capable or co-occurring enhanced SA Day Services.

14. An adult with serious and persistent mental illness whose symptoms are stable enough so that Intensive Day Treatment is not indicated; whose cognitive functioning is high enough to participate in and benefit from a co-occurring capable SA Day Services program without distraction; whose coping skills and abilities are sufficiently intact to allow attention to his/her substance abuse; and who can understand the emotional concerns related to the negative consequences and effects of addiction should be allowed to choose service in a SA Day Services program. An adult with serious and persistent mental illness may not be refused service in an SA Day Services program simply because he/she is seriously and persistently mentally ill. Likewise, a seriously and persistently mentally ill adult may not be refused service in a PSR program simply because he/she is abusing or dependent on alcohol or other drugs.
15. Adults with serious and persistent mental illness whose symptoms, cognition, functioning, or coping skills are sufficiently impaired to prevent participation or benefit from a co-occurring capable day services program but who meet the admission criteria for either PSR or SA Day Services, must be served by a co-occurring enhanced PSR or SA Day Services program.
16. The service guidelines for PSR Services and for SA Day Services will include the same requirements about cross training and capabilities of staff to recognize and treat adults with co-occurring disorders.
17. DMHMRSA will work to ensure that there is no financial disincentive to serving individuals with co-occurring disorders in any particular day services program.
18. Basic knowledge necessary for all staff serving persons with mental illness or substance abuse in "co-occurring capable" day services must include the content areas below. For programs that are "co-occurring enhanced," this knowledge must go beyond basic understanding and must demonstrate actual staff competencies in using that knowledge to serve adults with co-occurring disorders.
19. PSR and SA Day Services Program Managers and staff are encouraged to become familiar with ASAM's Patient Placement Criteria – 2R and current evidence-based practices literature about serving adults with co-occurring disorders.

GEORGIA DMHMRSA – BEST PRACTICES SUGGESTIONS

STAFF KNOWLEDGE AND CAPABILITIES REGARDING SERVING PERSONS WITH CO-OCCURRING DISORDERS

NECESSARY CAPABILITIES FOR SUBSTANCE ABUSE STAFF	NECESSARY CAPABILITIES FOR MENTAL HEALTH STAFF
• knowledge of mental illness diagnoses, symptoms, and cognitive impairments where applicable; • medications used to treat various types of mental illness and their effects, including undesired medication side effects and the effects of discontinuing these medications; • assessment of mental illness; • likely coping strategies of individuals with mental illness, including use and abuse of substances, • concept of role of family members and psychoeducational approaches for working collaboratively with them; • motivational counseling for clients who are not ready to take full responsibility for self-management and recovery from substance abuse; • behavioral counseling for those who are actively working on recovery; • denial about mental illness or its symptoms, while respecting and encouraging individual choice and responsibility; • individual strategies for preventing symptom exacerbation; and • difference between recovery and engagement concepts in mental health and in substance abuse.	• knowledge of substances of abuse and how they affect mental illnesses; • symptoms of withdrawal from various types of substances of abuse; • complications of interactions between psychotropic medications and substances of abuse, especially in detoxification and withdrawal processes; • assessment of substance abuse; • special considerations in assessing substance abuse in adults who have symptoms associated with a mental illness or who are taking or are candidates for taking prescribed medications for a diagnosed mental illness; • motivational counseling to use with clients who appear to be unmotivated for substance abuse treatment; • behavioral substance abuse counseling for those who are motivated to work toward abstinence; • denial and its role in addiction; • methods for overcoming denial while respecting and encouraging individual choice and responsibility; • relapse prevention strategies for persons with addictions; and • difference between recovery and engagement concepts in substance abuse and in mental health.

Mental Retardation/Developmental Disabilities Services

DD Day and Employment Services

DD Day and Employment Services

Day Supports

Definition of Service:
MRWP Day Support Services are designed to assist persons in the acquisition, retention and/or improvement of skills that create a quality and appropriate day for the consumer. This service is intended to assist the individual with community activities, facility-based training activities, pre-vocational activities, and community-based employment. These services are offered to persons who require intensive support or habilitation.

The following Day Supports services are offered:

DD Day Support Habilitation – Community
DD Day Support Habilitation – Facility
DD Day Support – Prevocational
DD Day Support – Community Based Employment

Individuals may receive community integrated day supports exclusively (100% DD Day Support Habilitation-Community). All other individuals receiving this service must receive **two of the four** service components (DD Day Support Habilitation - Community, DD Day Support Habilitation - Facility, DD Day Support / Pre-Vocational, or DD Day Support- Community Based Employment).

Refer to the service definitions that follow.

DD Day and Employment Services

Day Supports

Day Support Habilitation – Community

Definition of Service:
Day Support Habilitation-Community services are individualized services, which may include training in the areas of daily living skills (including leisure/recreation skills); communication training; mobility training; and programming to reduce inappropriate and/or maladaptive resources. The activities are provided in a community setting and focus on appropriate interactions that will typically occur in the community where the person lives but not in their home or residential setting. The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills or daily living and adaptive skills. These activities include assisting people with money management, teaching appropriate shopping skills, and teaching nutrition and diet information. The intended outcome of these activities is to improve the consumers' access to the community through increased skills and/or less paid supports. An individual may receive 100% of his/her Day Supports in this category of service or in combination with the other Day Support Services.

Note: Refer to service definition for Day Supports for Individuals with Developmental Disabilities.

Target Population:	Adults with mental retardation/developmental disabilities who need a comprehensive day service that is 100% community integrated or includes at a minimum two of the four DD Day Supports services.
Expected Benefit:	The intended outcome of these activities is to improve the consumers' access to the community through increased skills and/or less paid supports. The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills of daily living and adaptive skills.
MHMRIS: **Subunit & Modality**	Subunit — Modality 466 – DD Day Supports - Community Based Habilitation — 05 – Day Training
UAS: **Budget and Expense Categories**	401 – Day Supports - Community Based Habilitation
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities T2025 – Day Supports – Monthly T2025 U1 – Day Supports – 60 Hours T2025 U2 – Day Supports – 30 Hours T2025 U3 – Day Supports – 40 Hours

DD Day and Employment Services

Day Supports

Day Support Habilitation – Facility

Definition of Service:
Day Support Habilitation-Facility services are individualized, facility based and not in the consumer's home. These services may include training in the areas of daily living skills (including leisure/recreation skills); communication training; mobility training; and programming to reduce inappropriate and/or maladaptive resources. The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills of daily living and adaptive skills. These activities include assisting people with money management, teaching appropriate shopping skills, and teaching nutrition and diet information. The intended outcome of these activities is to improve the consumers' access to the community through increased skills and/or less paid supports. For an individual to receive this service, he/she must also receive DD Day Support Habilitation-Community, DD Day Support Pre-Vocational, or DD Day Support-Community Based Employment.

Note: Refer to service definition for Day Supports for Individuals with Developmental Disabilities.

Target Population:	Adults with mental retardation/developmental disabilities who need a comprehensive day service that includes at a minimum two of the four DD Day Support services.
Expected Benefit:	The intended outcome of these activities is to improve the consumers' access to the community through increased skills and/or less paid supports. The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills of daily living and adaptive skills.
MHMRIS: **Subunit & Modality**	Subunit: 467 – DD Day Supports – Facility Based Habilitation Modality: 05 – Day Training
UAS: **Budget and Expense Categories**	402 – Day Supports - Facility Based Habilitation
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities T2025 – Day Supports – Monthly T2025 U1 – Day Supports – 60 Hours T2025 U2 – Day Supports – 30 Hours T2025 U3 – Day Supports – 40 Hours

DD Day and Employment Services

MRWP Day Supports

Day Support – Prevocational

Definition of Service:
Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as rule compliance, attendance, increased attention span, task completion, problem solving, safety and appropriate social interaction skills in the workplace. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Activities included in this service are ***not*** primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span, safety and motor skills. For an individual to receive this service, he/she must also receive DD Day Support Habilitation-Community, DD Day Support Habilitation-Facility, or DD Day Support-Community Based Employment.

Note: Refer to service definition for Day Supports for Individuals with Developmental Disabilities.

Target Population:	Adults with mental retardation/developmental disabilities who need a comprehensive day service that includes at a minimum two of the four Day Support services.
Expected Benefit:	The intended outcome of these activities is to improve the consumers' access to the community through increased skills and/or less paid supports. The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills of daily living and adaptive skills.
MHMRIS: **Subunit & Modality**	Subunit — Modality 468 – DD Day Supports – Prevocational — 05 – Day Training
UAS: **Categories**	403 – Day Supports – Prevocational
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities T2025 – Day Supports – Monthly T2025 U1 – Day Supports – 60 Hours T2025 U2 – Day Supports – 30 Hours T2025 U3 – Day Supports – 40 Hours

DD Day and Employment Services

Day Supports

Day Support – Community Based Employment

Definition of Service:
Community Based Employment recipients must require long term and intensive direct or indirect job related support in job supervision during the workday. Community Based Employment includes activities needed to obtain and sustain paid work by individuals receiving waiver services, including job development, supervision and training. For an individual to receive this service, he/she must also receive DD Day Support Habilitation-Community, DD Day Support Habilitation-Facility, or DD Day Support/Pre-Vocational.

Note: Refer to service definition for Day Supports for Individuals with Developmental Disabilities.

Target Population:	Adults with mental retardation/developmental disabilities who need a comprehensive day service that includes at a minimum two of the four DD Day Support services.
Expected Benefit:	The intended outcome of these activities is to improve the consumers' access to the community through increased skills and/or less paid supports. The emphasis of training will be on assisting the individual in increasing self-help, socialization skills, skills of daily living and adaptive skills.
MHMRIS: **Subunit & Modality**	Subunit — Modality 469 – DD Day Supports – Community Based Employment — 06 – Work Activity
UAS: **Budget and Expense Categories**	404 – Day Supports – Community Based Employment
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities T2025 – Day Supports – Monthly T2025 U1 – Day Supports – 60 Hours T2025 U2 – Day Supports – 30 Hours T2025 U3 – Day Supports – 40 Hours

DD Day and Employment Services

Supported Employment

Definition of Service:
Support for people who, due to the severity of their disabilities, need ongoing support to work. Services include supports to choose, obtain and keep paid employment in community jobs. The scope and intensity of support may change over time, based on the needs of the consumer.
No one type of job or support model is assumed to be appropriate for all consumers. Services may be provided in a variety of settings that meet the specific service criteria of (1) paid employment (2) with opportunities to interact with people who do not have disabilities, and (3) the need for and provision of ongoing support. Wages must be paid in compliance with all applicable Department of Labor requirements.

Most jobs in this category are a minimum of 20 hours per week. When consistent with consumer needs and interests, quality indicators include increases in the number of hours worked, increases in wages and benefits, increased opportunities for interaction with co-workers and an increased utilization of natural supports (with a corresponding decrease in dependence on direct, agency provided support). Supported Employment services should focus on the consumer's career, rather than simply a job.

Target Population:	Individuals of working age with developmental disabilities who want to work and have a demonstrated need for ongoing supports to maintain employment.
Expected Benefit:	The individual has increased economic resources, has a valued role in the community and develops a level of self-sufficiency.
MHMRIS: **Subunit & Modality**	Subunit — Modality 471 – Sup. Emp. - Comm. Based Emp. Svcs. – Individual — 06 – Work Activity 472 – Sup. Emp. - Comm. Based Emp. Svcs. – Group-Enclaves — 06 – Work Activity 473 – Sup. Emp. - Comm. Based Emp. Svcs – Group-Mobile Crews — 06 – Work Activity 459 – Supported Employment – MRWP/CHSS 06 – Work Activity
UAS: **Budget and Expense Categories**	406 – Individual Supported Employment 407 – Group Supported Employment - Enclaves 408 – Group Supported Employment – Mobile Crews NONE - Supported Employment – MRWP/CHSS

Medicaid:	Developmental Disabilities
For possible related service(s) refer to Medicaid Procedure Code(s):	MRWP Supported Employment CHSS Supported Employment

Additional Service Information:
Supported Employment may be provided through a state Grant in Aide contract or through either of the two MR Medicaid waivers. In the MRWP, Supported Employment is a discreet service. Supported Employment may be provided through the CHSS waiver as part of the bundled service.

Supported Employment may be provided in individual or group settings. When contracts or Memorandums of Agreement require providers to report the types of settings in which Supported Employment has occurred, providers will report those settings using the following categories:

- Community Based Employment Services – Individual
- Community Based Employment Services – Group (Enclaves & Crews)

Definitions of these employment settings may be found under: Comprehensive Day and Employment Services – Community Based Employment Services – Individual & Group.

DD Day and Employment Services

MRWP/CHSS Day Habilitation

Definition of Service:
Day Habilitation Services are aimed primarily at the development, acquisition enhancement and maintenance of skills that further the client's ability to function independently in the home and the community. Services include interventions in the areas of social, emotional, physical, and intellectual development and may include training in areas such as daily living skills; communication; mobility; reduction of maladaptive behaviors; and use of community resources. Services of a developmental nature, including evaluations and prescriptive training, may be included as defined in the consumer's service plan. Services focus on enabling the consumer to attain his/her maximum functional level and should be coordinated with any other services or therapies listed in the service plan.

Target Population:	Adults with mental retardation for whom employment services are not appropriate.
Expected Benefit:	Consumers will be afforded the opportunity for growth and development while having the opportunity for social and physical integration in home and community activities
MHMRIS:	Subunit: 350 – Day Habilitation Modality: 05 – Day Training
UAS: **Budget and Expense Categories**	NONE
Medicaid: **service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities T2021 – Day Habilitation Hourly Services T2025 U7 TG – Community Habilitation & Support Services (CHSS) T2025 U7 – Community Habilitation & Support Services Or Integrated Resource Services (CHSS/IRS)

Additional Service Information:

1. If the consumer is receiving Day Habilitation as a component of the CHSS bundled service, each service should be entered in MHMRIS separately even though they are being billed as a bundle.
2. Day Habilitation is not an employment service and should not be reported as employment.

DD Day and Employment Services

Comprehensive Day Services

Definition of Service:
Comprehensive Day services are an array of state/SSBG (contract) funded employment and/or non-employment services that have typically been provided by MR Day Service Centers.

Employment services may be facility or community based. All employment services must comply with Part 525 of the Fair Labor Standards Act. Both employment and non-employment services should target supporting consumers in having a valued role in typical community settings.

Non-employment services may be provided in a facility, in typical community settings or, in some cases, in a consumer's home (if the individual is not receiving RTS, Personal Support or Contract Funded Residential Supports).

Indirect Intervention Services may be provided specifically on behalf of individuals in an effort to identify and facilitate ongoing supports, including natural supports for an individual to access and participate in community activities or provide support to community peers when a consumer is participating in the same community activity.

Direct non-employment services may include training and support in self-help, recreational/ leisure, money management and other skills that may facilitate community access. All DD Comprehensive Day Services are based on the needs, preferences and interests of the individual consumer as documented in the Individual Services Plan (ISP). DD Comprehensive Day Services must comply with the Social Services Block Grant (SSBG) regulations found in the Provider Manual.

Target Population:	Individuals with MR/DD who need one or more of an array of facility and/or community based day services, and who either are ineligible for Medicaid Home and Community Based Services, or for whom wavier services are not currently available.
Expected Benefit:	The individual has economic resources, increased choice, more meaningful days and occupies a valued role in his/her community.
MHMRIS: **Subunit & Modality**	Subunit — Modality 482 – Comprehensive Day Svcs. – Non-Emp. & Indirect Intervention Svcs. — 05 - Day Training 483 – Comprehensive Day Svcs. – Community Based Employment Svcs.–Individual — 06 – Work Activity 484 – Comprehensive Day Svcs. – Community Based Employment Svcs.-Group — 06 – Work Activity 485 – Comprehensive Day Svcs. – Facility Based Employment Svcs. — 06 – Work Activity

UAS: Budget and Expense Categories	405 – Comprehensive Day Services
Medicaid: For possible related service(s) refer to Medicaid Procedure Code(s):	NONE

Additional Service Information:
When employment services are being provided under this service category, those employment services are reported as:

Community Based Employment Services – Individual, or
Community Based Employment Services Group
- Enclave or
- Mobile Crew; or

Facility Based Employment.

When Non-Employment services are being provided under this service category, those non-employment services are reported as:

Community Based Non-Employment Services,
Facility Based Non-Employment Services, or
Indirect Intervention Services

Community Residential Services for Persons with Developmental Disabilities

Definition of Service:
Provides a variety of community living arrangements and ranges of training and supervision to meet a broad range of needs. The particular type of residential services an individual receives over time should vary according to his/her fluctuating needs. Based on consumers' needs, residential services may be highly structured, heavily supervised, and programmatically intensive, or the residential service may facilitate a relatively independent lifestyle requiring only a modest amount of staff support. Residential services should be a part of the community and the environment and size of the residential option should blend in with the surrounding homes. Whenever possible, consumers should be supported in their natural homes, particularly individuals under age 22.

The following Residential Supports are provided:

MRWP/CHSS Residential Training and Supervision
MRWP/CHSS Personal Supports
Contract Funded Residential Supports

COMMUNITY RESIDENTIAL SERVICES
for Persons with Developmental Disabilities

MRWP/CHSS Residential Training and Supervision

Definition of Service:
Residential Training and Supervision (RTS) services are targeted for people who require intense levels of support. Consumers live in small group settings of four or fewer. The provision of Residential Training and Supervision is limited to individuals living in homes that are owned or rented by the service provision agency. RTS homes with two or more adults must have a Personal Care Home Permit or be licensed under the Community Living Arrangements issued by the Department of Human Resources, Office of Regulatory Services. Services may include assistance with, and/or training in activities of daily living, such as bathing, dressing, grooming another personal hygiene, feeding toileting, transferring, etc. Services may include assisting with therapeutic exercises, supervising self-administration of medication and performing other services essential to health care at home. Emphasis is placed on supporting consumers in participating in the life of the community, including accompanying consumers and facilitating their participation in shopping, recreational activities, personal banking, etc. Services often include training and assistance in household care, such as meal preparation, clothes laundering, housecleaning, and other similar tasks.

The services provided and the level of intensity of services are specific to the individual consumer and detailed in his/her Individual Services Plan (ISP).

Target Population:	People with developmental disabilities who require residential supports to remain in their communities.
Expected Benefit:	Consumers have a residence that provides the supports needed to remain and participate in their community.
MHMRIS: **Subunit & Modality**	Subunit — Modality 517 – Residential Training & Supervision (RTS) — 04 – Comm. Res.
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities T2016 – Residential Training and Supervision (RTS I) T2016 TF – Residential Training and Supervision (RTS II) T2016 TG – Residential Training and Supervision (RTS III) T2016 U2 – Residential Training and Supervision (RTS IV) T2025 U7 TG – Community Habilitation & Support Services (CHSS) T2025 U7 – Community Habilitation & Support Services (CHSS) Or Integrated Resource Services

Community Residential Services
for Persons with Developmental Disabilities
MRWP/CHSS Personal Support Services

Definition of Service:
Personal Support services include an array of services which are required to maintain and assist persons with mental retardation/developmental disabilities to live in community settings. This service is provided to people who live in their own home or in a foster or family care setting. Personal Support services may not be delivered to a person living in a home leased or owned by the service delivery agency. Agencies providing personal supports must have a Private Home Care Provider License from the Department of Human Resources, Office of Regulatory Services. Personal Support services may include assistance and training in activities of daily living, such as bathing, dressing, grooming, feeding, toileting, transferring and other similar tasks. Emphasis is placed on supporting the consumer in participating in his/her community such as shopping, recreation, personal banking and other community activities. Services may include assistance with therapeutic exercises, supervision of self-administration of medication and other services essential to health care at home.

The setting in which a consumer is served should be designed specifically for the person and should accommodate fluctuations in the person's needs for various services. The services provided and the level of intensity of services are specific to the individual consumer and detailed in his/her Individual Services Plan (ISP).

Target Population:	People with developmental disabilities who need support to continue living in their own homes.	
Expected Benefit:	Consumers have a residence that provides the supports needed to remain and participate in their community.	
MHMRIS: **Subunit & Modality**	Subunit 319 – Personal Supports	Modality 08 – Outpatient
UAS: **Budget and Expense Categories**	NONE	
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	T2025 U5 – Personal Support Services T2025 U7 TG – Community Habilitation & Support Services (CHSS) T2025 U7 – Community Habilitation & Support Services (CHSS) Or Integrated Resource Services	

Community Residential Services
for Persons with Developmental Disabilities

Contract Funded Residential Supports

Definition of Service:
Contract Funded Residential Supports are intended for individuals with MR/DD who require some residential supports to remain in the community and who either require less intensive supports than those described in the definitions of MRWP/CHSS Residential Training and Supervision or MRWP/CHSS Personal Support, or who are not eligible for waiver services. In most cases, direct support is intermittent, supporting consumers in activities such as preparing meals, managing personal finances or accessing generic community resources. However, in all cases, the type, frequency and intensity of residential supports must be documented in the Individual Services Plan (ISP). Services are aimed at supporting consumers in having increased opportunities to participate in their own community and in exercising choice in regard to their services and daily routines. Contract Funded Residential Supports may be provided to consumers living in a home owned or rented by the support agency or to consumers living in a home or apartment that they own or rent themselves. Homes owned or rented by the support agency must be licensed either as Personal Care Homes or Community Living Arrangements. When services are provided in homes owned or rented by the consumer, the agency must have a Private Home Care license. Services are based on the unique support needs, preferences and interests of the individual being service as evidenced by his/her ISP.

Target Population:	People with MR/DD who need relatively moderate support to remain successfully in the community and/or are not eligibility for waiver funded residential services.	
Expected Benefit:	Consumers have the supports they need to remain and participate in their community.	
MHMRIS: **Subunit & Modality**	Subunit 516 – Community Residential Supports	Modality 04 – Comm. Res.
UAS: **Budget and Expense Categories**	411 – Community Residential Supports	
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE	

Respite

Definition of Service:
Respite provides brief periods of support or relief for caregivers or individuals with disabilities. Respite is provided: (1) when families or the usual caretakers are in need of additional support or relief; or (2) when the consumer needs relief or a break from the caretaker; (3) when a consumer is experiencing a behavioral crisis and needs structured, short-term support; or (4) when relief from care giving is necessitated by unavoidable circumstances, such as a family emergency. Respite may be provided in-home (provider delivers service in consumer's home) or out-of-home (consumer receives service outside of their home), and may include day activities as well as overnight. Respite Services are further defined by the designations, Maintenance Respite and Emergency/Crises Respite:

Maintenance Respite provides brief periods of support or relief for caregivers or individuals with disabilities. Maintenance Respite is planned or scheduled respite and is provided (1) when families or the usual caretakers are in need of additional support or relief; or (2) when the consumer needs relief or a break from the caretaker. Maintenance Respite may be provided in-home (provider delivers service in consumer's home) or out-of-home (consumer receives service outside of their home), and may include day activities as well as overnight.

Emergency/Crises Respite is intended to be a short term service for a consumer experiencing a crisis (usually behavioral) and requires a period of structured support and or/programming, or respite services are necessitated by unavoidable circumstances, such as a family emergency. Emergency/Crises Respite may be provided In-Home (provider delivers service in consumer's home) or Out-Of-Home (consumer receives service outside of their home), and may include day activities as well as overnight.

Target Population:		
Expected Benefit:		
MHMRIS: **Subunit & Modality**	Subunit 112 – Respite – Emergency 113 – Respite – Maintenance	Modality 08 – Outpatient * 08 – Outpatient * (* even if overnight)
UAS: **Budget and Expense Categories**	423 – Respite	
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE	

Additional Service Information:

1. Additional information and requirements regarding Respite Services for individuals with mental retardation, autism and other developmental disabilities can be found in the Provider Manual under, "Operating Procedures for Respite and Family Support Services".
2. Enrollments to MHMRIS for Respite-Emergency requires that a consumer be enrolled and released each time the consumer receives the service and may not be left open as an open enrollment. For Respite – Maintenance a consumer may be enrolled in this service and left open if the service is a part of the consumer's treatment plan and the consumer is to receive this on a continuous basis.
3. Respite may be provided through both wavier and contract funding.
   FY'06 regions may contract for unspecified "Respite", or may specify numbers of consumers served in "Emergency/Crises Respite" vs. Maintenance Respite. However, whether or not the contract specifies simply Respite, Maintenance Respite or Emergency/Cries Respite, all providers will report the services delivered as either Maintenance or Crises/Emergency, consistent with the definitions above.

Support Coordination

Definition of Service:
Support Coordination is a targeted case management service for eligible recipients that identifies, coordinates, and reviews the delivery of appropriate services as prescribed in the recipient's individual service plan. The Support Coordinator assures that the individual gains access to needed medical, social, educational, transportation, housing, nutritional, and other services by serving as the individual's primary advocate. The Support Coordinator also encourages the use of various community resources through referral to appropriate traditional and non-traditional providers and by leveraging additional natural resources. By coordinating the services of both paid professionals and unpaid non-professionals, the Support Coordinator is able to address needed individualized supports that might otherwise remain unfulfilled. Because the Support Coordinator is accountable for maximizing the individual's health and safety, this coordination of combined expertise and involvement and leveraging of additional resources provides the best assurance that health and safety will be met and that services are provided with quality in a meaningful way to the individual.

Target Population:	Individuals, including both Medicaid and non-Medicaid recipients, who are mentally retarded or developmentally disabled and who currently receive or are on the short-term planning list to receive community based services through the State of Georgia, Department of Human Resources, DMHDDAD.
Expected Benefit:	The primary purpose of support coordination services is to maximize the health and safety of service recipients by maintaining a vigilant focus on the consumer to ensure that their well being respected and supported through the delivery of holistic quality services.
MHMRIS:	Subunit: 470 – DD Support Coordination Modality: 08 - Outpatient
UAS: **Budget and Expense Categories**	432 – Support Coordination
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities Y3191 – Support Coordination

Additional Service Information:

1. Support Coordination is provided by regionally contracted Support Coordination agencies only.

Intake & Evaluation Services

Definition of Service:
Intake and Evaluation is the single point of entry into MR/DD services. The intake team is responsible for providing uniform screening/evaluation functions for all individuals entering or already in the system. A common protocol is used statewide for intake to assure the existence of a centralized mechanism to receive referrals for all MR/DD services including waiver services and admission requests to the state's ICF/MR. Intake and evaluation functions include conducting all intake and screening for applicants to MR/DD services, performing comprehensive evaluations and annual assessments, participating in service plan development, and conducting level of care determinations for individuals who receive Medicaid waiver services. Based on needs identified in the assessments Intake and Evaluation staff make recommendations of the types of services and supports that will guide the development of the person centered ISP. Intake and Evaluation also assist in managing the planning list and provide scheduled training technical assistance for providers. The technical assistance and consultation is provided to strengthen the service system infrastructure and targeted primarily to direct support staff. It is intended to result in consistent strategies, procedures, and skills regarding best practices related to service delivery.

Target Population:	Individuals applying for DD services through the DMHDDAD, and all individuals currently served in the DMHDDAD DD services system	
Expected Benefit:	Provides access to the DMHDDAD DD services system and assures an independent assessment of ongoing consumer needs.	
MHMRIS: **Subunit & Modality**	Subunit 902 – DD Intake & Evaluation	Modality 08 - Outpatient
UAS: **Budget and Expense Categories**	431 – Intake & Evaluation	
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE	

Additional Service Information:

Services are provided by regionally contracted Intake & Evaluation agencies or by publicly operated teams.

Services may be provided with state grant in aid or Medicaid funding.

Specialized Services
For People with Developmental Disabilities

Definition of Service:
Medicaid Waiver services that include Specialized Services, Specialized Medical Equipment, Specialized Medical Supplies, Vehicle Adaptations and Environmental Adaptations.

Specialized Services and Medical Equipment includes devices, controls or appliances, ancillary supplies and equipment specified in the Individual Support Plan (ISP) which enable the consumer to increase his/her abilities to perform activities of daily living and to interact more independently with his/her environment.

Medical Equipment and Environmental Adaptations includes those physical adaptations to the residence, required by the ISP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in his/her home.

Target Population:	Individuals with DD served in either of the MR/DD Medicaid waivers who need Specialized Services and Medical Equipment or Environmental Accessibility Adaptations to remain in and participate in their community.	
Expected Benefit:	Services will allow individuals to remain is community settings.	
MHMRIS:	Subunit 465 – Specialized Services	Modality 08 - Outpatient
UAS: **Budget and Expense Categories**	NONE - Medicaid Only	
Medicaid: **service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities MRWP & CHSS	

Additional Service Information:
Family Support Services may be a source of Specialized Services for Non-Waiver consumers who need those services.

Family Support

Definition of Service:
Services provided to or purchased for individuals and their families, based on their identified needs. Family Support is actually an array of individualized goods, services, supports, adaptive devices, or architectural modifications necessary to maintain the person in the home. Family Support is not generally seen as a crisis service. Rather, it is provided to families with the goal of preventing crises that can result in the need for out of home placements.

Target Population:	Individuals with mental retardation, autism or other developmental disabilities who live in their family's home, or individuals living in an alternate placement who are preparing to return to live with their family.
	Caregivers are able to continue supporting and caring for an individual when additional supports are provided. The individual is able to continue to live with his/her family.
MHMRIS:	Subunit / Modality 254 – Family Supports – MR / 08 – Outpatient 354 – Family Supports – Autism / 08 – Outpatient 454 – Family Supports – DD / 08 – Outpatient
UAS: **Budget and Expense Categories**	422 – Family Supports – MR 511 – Autism Services 510 – DD Family Support
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. Additional information and requirements regarding Family Support services for people with mental retardation, autism and other developmental disabilities can be found in the "Operating Procedures for Family Support Services".
2. Eligibility is as follows for MR/DD:
    a. Family Support – (Subunit 254) Individuals must meet the Division's criteria for DD services and must be unduplicated in the count of individuals receiving services through Subunit 354 (Autism Family Support) and Subunit 454 (DD Family Support Services).
    b. Family Support – DD, (Subunit 454), a person must have a Developmental Disability diagnosis, other than Mental Retardation or Autism Services.
    c. Family Support – Autism, (Subunit 354), a person must have a diagnosis within the Autism Disorder Spectrum.
    d. . The intent is that individuals who receive family support funding receive funding from only one of the three fund sources.

Natural Support Enhancement Services

Definition of Service:
Natural Support Enhancement Services (NSE) are designed to give individuals with developmental disabilities assistance in developing and strengthening the skills necessary to live more independently and to experience a valued role in the community. Services include training or assistance in self-help, social interaction, communication, money management skills, behavior support, and daily living and adaptive skills. Emphasis is placed on fostering participation in social and leisure activities as well as managing health and dietary needs. Respite support may be available as part of a person's support system. Consumers receiving this service have a support network that may be comprised of family, neighbors, community members, or friends who want to have an active role in supporting the individual.

Natural Support Enhancement Services are targeted for people who currently live or desire to live in the community and who have access to a natural support system.

Training for members of a consumer's natural support network may focus on any area appropriate to the consumer's goals. The outcome of this training is to develop and support greater access to the community by the consumer.

Only items and services approved in the individual budget may be purchased.
Services and supports are provided with attention to health and safety.
Training and supports are offered to consumers in a variety of settings that are appropriate to the member's developmental level, age, and culture.

Target Population:	People with developmental disabilities and their families who have strong natural support system.
Expected Benefit:	Individual with disabilities will develop new skills or receive the necessary supports that facilitate their increasing participation in regular activities of his/her community. Members of the consumer's support system are increasingly able to provide quality supports that foster the inclusion of the individual.
MHMRIS: **Subunit & Modality**	Subunit: 364 – Natural Support Enhancement Services Modality: 08 - Outpatient
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities

Natural Support Therapies

Definition of Service:
Natural Support Therapies are designed to give consumers with DD the opportunity to access specialized treatment within their natural support network. Natural Support Therapies were developed as an alternative to home-based therapies available in the Medicaid state plan. Natural Support Therapies include the following individual services:

Physical Therapy – The application of specialized treatments such as natural forces, heat exercise and certain mechanical devices necessary to further develop or maintain essential basic skills of the consumer. The service includes initial assessment, the provision of treatments, the assessment of progress and the teaching of family members or natural support providers the techniques to use with the individual

Occupational Therapy – This service uses goal-oriented activities to provide training in the development or use of physical and mental capacities, and the development or maintenance of skills for self-care and daily living skills. The services include an initial assessment, the assessment of progress and treatment. The services also encompass the training of family members or support providers in procedures or activities to use with the individual with disabilities. The activities are directed at accelerating the attainment of developmental milestones and, when appropriate, activities that are directed toward vocational application.

Speech and Hearing Therapy – This service is the provision of treatments designed to improve speech and hearing defects that interfere with the person's overall ability to function. These services include an initial assessment for speech and hearing therapies, the provision of treatments, assessment of progress and the teaching of family members or support providers the techniques to use with the individual.

Nutritional Therapy Services – This service is the provision of on-going nutritional therapy and member/family education for the diet therapy for individuals who require additional supports beyond consultation and assessment services.

Target Population:	Individuals enrolled in Natural Support Enhancement Services or Consumer Directed Natural Support Enhancement Services who need these services, and for whom there is a reasonable expectation that the goals of the therapy can be achieved in the necessary time frame	
Expected Benefit:	Individuals will receive services that address their individual needs and allow them to remain in their home and community.	
MHMRIS: Subunit & Modality	Subunit 463 – Natural Support Therapies	Modality 08 - Outpatient

UAS: Budget and Expense Categories	NONE
Medicaid: For possible related service(s) refer to Medicaid Procedure Code(s):	Developmental Disabilities

Additional Service Information:

Persons receiving Home Based Services through Medicaid's state plan are not eligible to receive Natural Support Therapies at the same time.

Transportation to and from these services is not included in the rate.

Natural Support Therapy providers must comply with the DHR and DMA's conditions of participation.

Services are provided by a licensed professional and by order of a physician.

Therapists must be licensed to practice in the State of Georgia.

Consumer Directed
Natural Support Enhancement Services

Definition of Service:
Consumer Directed Natural Support Enhancement Services provides consumers and their natural support networks the option to self-direct the NSE services specified in the Individual Services Plan. Skill development of the consumer's natural support network is specific to outcomes of developing and supporting enhanced access to the community by the individual. Individuals that participate in Consumer Directed NSE Services will have an individual services budget. Consumer Directed NSE Services includes a Person-Centered Planning Process directed by the consumer and/or his family or representative. These services will be incorporated into the Individual Services Plan (ISP).

Consumer Directed Natural Support Enhancement Services will assist an individual to continue living at home and will meet the individual's needs through a range of possible supports and skills development, with includes self help and personal care, social interaction and participation in activities within the community, daily living skills, accessing recreational and leisure, accessing and using transportation, communication, including use of assistive technology, understanding of and appropriate response to the individual's behavioral needs, and accessing the appropriate community supports and accessing and coordinating financial and life planning services.

Target Population:	Individuals with developmental disabilities receiving MRWP funded Natural Support Enhancement, who live in their own homes and have a support network that want to have and active role in supporting the individual with the responsibilities of consumer direction.
Expected Benefit:	Individual with disabilities will develop new skills or receive the necessary supports necessary to live in the community and to direct their own care.
Subunit & Modality	Subunit: 464 – Consumer Directed NSE & Financial Support Services Modality: 08 - Outpatient
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	Developmental Disabilities MRWP Consumer-Directed Natural Support Enhancement Services Only

Additional Service Information: This is a new MRWP service. The service will be available statewide by the end of FY'06, but implementation will be phased in over the course of FY'06. Consumers and/or their families or representatives who opt for this service must be willing and able to, with support, direct their NSE Services and perform employer functions, such as interviewing, checking references, hiring, supervising, and firing. Consumers or families/representatives who elect to self-direct NSE Services may continue to receive other waiver services under the traditional service delivery system.

Consumer Directed Natural Support Enhancement participates must utilize the Financial Support Serviced defined below and in the MRWP.

Financial Support Services

Definition of Service:
Financial Support Services (FSS) are designed to perform finance and related functions for the individual and/or family or representative who enroll in Consumer-Directed NSE Services. FSS includes all fiscal support functions necessary to assure that appropriate taxes and fees are deducted and funds are managed and distributed as intended for Consumer-Directed NSE Services in the Individual Service Plan. FSS includes technical assistance to individuals and families/representatives, including answering questions and providing direction with all payroll functions including completing and reviewing timesheets.

Target Population:	Individuals with developmental disabilities receiving MRWP funded Consumer-Directed Natural Support Enhancement Services.
	Consumers will receive fiscal support and accounting consultation services that will support their self-directing NSE Services. Financial Support Services assure that funds to provide Consumer-Directed NSE Services outlined in the ISP are managed and distributed as intended.
MHMRIS: Subunit & Modality	Subunit: 464 – Consumer Directed NSE & Financial Support Services Modality: 08 – Outpatient
UAS: Budget and Expense Categories	NONE
Medicaid: **service(s) refer to Medicaid Procedure Code(s):**	MRWP Financial Support Services only

Additional Service Information: This is a new MRWP service. The service will be available statewide by the end of FY'06, but implementation of will be phased in over the course of FY'06. Consumers and/or their families or representatives who opt for this service must be willing and able to, with support, direct their NSE Services and perform employer functions, such as interviewing, checking references, hiring, supervising, and firing. Consumers or families/representatives who elect to self-direct NSE Services may continue to receive other waiver services under the traditional service delivery system.

Behavioral Support Team Services

Service Definition:
The goal of Behavioral Support Team Services is to increase and enhance community provider capacity by assisting agencies to handle crisis within their respective organizations and communities. The services emphasize a systems approach to behavioral interventions with an emphasis placed on early identification of problem behaviors. Specialized interventions are based on positive behavioral approaches. Services include, but are not limited to, positive behavioral support training, behavioral consultations, and technical assistance for community providers and families. Services combine the application of applied behavior analysis within the context of person-centered values.

Through a functional assessment, support teams are able to develop behavioral intervention plans that are positive, proactive, educative and functional. Most plans or recommendations include proactive strategies for changing the environment so the triggering events are removed, teaching new skills that replace behavior, or maximizing rewards for appropriate behaviors.
While the emphasis is on eliminating or reducing problem behaviors, this approach also emphasizes improving the overall quality of life of the individual. Outcomes may focus on improving quality of life by participation in the community, gaining or maintaining satisfying relationships, making choices, or expressing personal needs.

Target Population:	Individuals with DD who exhibit problems behaviors such as physical/verbal aggressions, self injurious behaviors, property destruction, tantrums or other behaviors that interfere with individuals' participation in community life	
Expected Benefit:	Individuals will get the behavioral support they need in the community, rather than having to rely on psychiatric hospitalization and emergency rooms for crises management. Individuals are expected to have an improved quality of life through increased participation in the community, gaining or maintaining more satisfying relationships, enhanced skills in expressing personal needs and increased choice.	
MHMRIS: **Subunit & Modality**	<u>Subunit</u> 461 – Behavioral Support Team Services	<u>Modality</u> 08 – Outpatient
UAS: **Budget and Expense Categories**	421 – Behavioral Support Team Services	
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE	

Prevention Services

Prevention Services

Service Definition: Prevention is an active process of creating conditions and fostering personal attributes that promote the well being of people (Lofquist 1987). Prevention services aim to create conditions in multiple domains (individual, peer, family, school, community) and foster personal attributes, including building resilience and increasing knowledge and awareness, which promote the well being of individuals and their communities. Prevention services are based on prevention science, which employs a logic model comprising a) a needs assessment, b) planning, c) implementation, and d) evaluation to create and deliver effective programs with positive outcomes. Prevention activities enhance protective factors (resiliency and developmental assets), and reduce those risks and negative factors that place communities and individuals at risk for behaviors and/or problems associated with substance related disorders, violence, and mental disorders.

The Division of MHDDAD is the managing agency and programmatic authority for the delivery of federally and state-funded prevention services in the areas of 1) Substance Abuse Prevention and 2) ATOD and Violence Prevention. Substance Abuse Prevention (SAP) services are funded primarily by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (SAMHSA/CSAP) and The Governor's portion of the US Department of Education's Safe and Drug Free Schools and Communities Program reauthorized as No Child Left Behind, (NCLB) 2001.

Substance Abuse Prevention

MHDDAD seeks to be responsive to CSAP's mission of bringing effective prevention programs to all communities and has, effective 2004, developed the Strategic Prevention Framework, which incorporates SAMHSA's strategic goals in accordance with the *Government Performance Results Act* of 1993 or GPRA. These goals are:

- *Accountability – requiring the evaluation of prevention programs to demonstrate outcomes*
- *Capacity – addressing the specific and immediate prevention service capacity needs*
- *Effectiveness – supporting the identification and promotion of promising and model prevention programs.*

Thus, Prevention services must be research-based and outcomes oriented.

US DOE SDFSC/NCLB funds are to be directed at non-school based prevention programming through the collaboration of community-based organizations. All MHDDAD providers are to

develop and implement SAP or ATOD and Violence prevention programs designed to meet these goals.

The Center for Substance Abuse Prevention (CSAP) regulations stipulate that states and their sub-recipients use SAPTBG funds to support and deliver a range of prevention services and activities in six key primary prevention areas as a part of a comprehensive system for preventing substance abuse. The six areas or primary prevention strategies are directed at individuals not identified to be in need of treatment and include:

1) **Information dissemination** to promote awareness of the nature and extent of alcohol, tobacco and drug use, abuse and addiction; its effects on individuals, families and communities, and dissemination is characterized by one-way communication from the source to the audience, with limited interaction between the two. Examples include clearinghouses/information resource centers, media campaigns, and speaking engagements.

2) **Education** to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities. Education is characterized by two-way communication, involving interaction between the educator/facilitator and the participant. Examples include children of substance abusers (COSA) groups, classroom educational services, and parenting/family management services

3) **Alternatives** to activities involving alcohol, tobacco and other substance use for at risk populations and sub-populations. Examples include alcohol, tobacco and other drug free social/recreational events, community drop-in centers, community service projects.

4) **Identification and Referral** of adults, children and adolescents engaged in the illegal/age inappropriate use of tobacco or alcohol, and/or first use of illicit drugs, in order to assess if their behavior can be reversed through education. (*Note: Activities intended to assess treatment needs are not included within this strategy.)* Examples include employee and student assistance programs.

5) **Community-Based Process** to build prevention and treatment capacity at the local level, including, interagency collaboration, coalition building and networking. Examples include community development services, community teams/coalitions, and training services.

6) **Environmental Strategies** to affect community standards that will result in a reduction of the incidence of the use of alcohol, tobacco and other substances. Strategies include legal and regulatory initiatives, as well as service and action-oriented initiatives. Examples include preventing underage sale of tobacco products (Synar Amendment), establishing ATOD-free school/workplace policies, and changing environmental codes, ordinances, regulations, and legislation.

Violence Prevention

Although current funding targets substance abuse and violence prevention, it is recognized that SAP strategies have been shown to be effective with problems associated with mental illness, mental retardation, some developmental disabilities and delays, and other negative conditions such as crime, teen pregnancy, substance abuse related child abuse and neglect, school failure and homelessness. As a result, MHDDAD seeks to address requirements of the US DOE in the areas of ATOD and violence prevention as an approach to mitigate against the factors that contribute to academic underachievement and promote pro-social development and behaviors.

The Principles of Effectiveness were developed by the US DOE SDFSC to help schools achieve safe learning environments where students are free from fear of violence and influence of drugs. Under Title IV of the NCLB act, local prevention programs and activities are required to meet these principles. This means that the prevention program or activity must:

- Be based on an *assessment of objective data* regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served.

- Be based on an established *set of performance measures* aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug-free learning environment.

- Be based on *scientific research* that provides evidence that the program to be used will reduce violence and illegal drug use.

- Be based on an *analysis of the data* reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the State identified through evidence-based research.

- Include *meaningful and ongoing consultation with and input from parents* in the development of the application and administration of the program or activity.

- Be *evaluated periodically against locally selected performance measures* and modified over time to refine, improve, and strengthen the program.

Youth violence is a complex public health problem with many risk factors, including individual beliefs and behaviors such as early aggression and use of alcohol or other drugs; family characteristics such as spousal abuse and lack of parental supervision; peer and school influences such as associating with delinquent friends; and environmental factors such as access to firearms. (Dahlberg 1998).

The Centers for Disease Control and Prevention Injury Center promotes the use of four distinct

strategies for combating the problem of youth violence.

Parent- and Family-Based Intervention
Parent- and family-based interventions are designed to improve family relations. There is growing evidence that these interventions, especially those that start early and recognize all the factors that influence a family, can have substantial, long-term effects in reducing violent behavior by children. Parent and family-based interventions combine training in parenting skills, education about child development and the factors that predispose children to violent behavior, and exercises to help parents develop skills for communicating with their children and for resolving conflict in nonviolent ways. This type of intervention is ideal for families with very young children and for at-risk parents with a child on the way.

Home-Visiting Intervention
Home-visiting interventions bring community resources to at risk families in their homes. During home visits, intervention staff provides information, healthcare, psychological support, and other services that participants need to function more effectively as parents. These programs have helped improve maternal health and pregnancy outcomes, increase employment and education among young parents, reduce reliance on welfare, improve children's mental and physical health, reduce childhood injuries, and reduce criminal behavior by young people. This strategy is ideally implemented with families who are expecting or have recently had their first child.

Social-Cognitive Intervention
Social-cognitive interventions strive to equip children with the skills they need to deal effectively with difficult social situations, such as being teased or being the last one picked to join a team. They build on the social-cognitive theory, which posits that children learn social skills by observing and interacting with parents, adult relatives and friends, teachers, peers, and others in the environment, including media role models (Bandura 1986). Social-cognitive interventions incorporate didactic teaching, modeling, and role-playing to enhance positive social interactions, teach nonviolent methods for resolving conflict, and establish or strengthen nonviolent beliefs in young people.

Mentoring
Mentoring – the pairing of a young person with a volunteer who acts as a supportive nonjudgmental role model – has been touted by many as an excellent means of providing a child or adolescent with a positive adult influence when such an influence does not other wise exist. Evidence has shown that mentoring can significantly reduce violent behavior, improve school attendance and performance, decrease the likelihood of drug use, and improve relationships with friends and parents (Sipe, 1996).

A single intervention conducted in isolation is not likely to solve the problem of youth violence as multiple factors contribute to violent behavior. The most effective programs include several complimentary types of interventions. For example, a mentoring program to help teens avoid gang membership may be complemented by an intervention that offers alternative after-school

activities.

Mental Health Promotion

Mental health promotion and prevention are best practices for increasing positive functioning and resilience, decreasing the risk of developing mental illness, and facilitating recovery. With this in mind, the National Association of State Mental Health Program Directors (NASMHPD) has adopted SAMHSA/CSAP's Strategic Prevention Framework for the development of policies and practices that will provide:

- *Earliest possible* identification and intervention in mental health problems
- Reduction of the incidence of mental illness and suicide
- Prevention of disability due to mental illness and co-occurring conditions
- Prevention of conditions commonly associated with mental illness including medical illness, substance abuse and trauma

Target Population:	Substance abuse prevention services are based on the Continuum of Care model promulgated by the Institute of Medicine (IOM). This model identifies three target population categories and provides guidance in matching specific prevention programs to each target population according to the needs of the population and the objectives and interventions of the various prevention programs: ▪ **Universal programs** (e.g. mass media, school-based health curricula) target the general population. ▪ **Selective programs** (e.g. mentoring programs for children with school performance or behavioral problems) target those at higher than average risk for substance abuse. Individuals are identified on the basis of the nature and number of risk factors to which they are exposed. ▪ **Indicated programs** (e.g. parenting programs for parents with substance abuse problems) target those already using substances or engaging in other high-risk behaviors (such as delinquency) to prevent chronic use.
	Substance Abuse Prevention: This strategic effort is in direct support of National Drug Control Strategy goals: 1) reduce "current use" of illegal drugs by 8th, 10th, and 12th graders by 25% by year end 2010; and 2)reduce "current use" of illegal drugs by young college and working adults, ages 18-25 by 25% by year–end 2010. **Violence Prevention:** The use of prevention strategies that have been shown to reduce these risk factors, and promote protective

	factors can help reduce the aggressive and violent behaviors seen in schools and communities. Young people can be taught how to avoid violent situations and develop the skills needed to resolve conflicts without resorting to violence. Parents can also be supported in providing a nonviolent home. Mentors can serve to provide nonviolent role models. **Mental Health:** The prevention of mental disorders includes interventions before and after the initial onset of a disorder. Interventions targeted to a population (universal, selective) before the initial onset will prevent the occurrence or slow down the progression of the disease. Interventions targeted to a population (indicated) after the initial onset will slow down the progression of the disease, prevent comorbidity, prevent relapse, and decrease the disease burden.
MHMRIS: **Subunit & Modality**	Subunit: N/A Modality: N/A
UAS: **Budget and Expense Categories**	850 – Safe and Drug Free Schools and Communities/NCLB 2001 reauthorized 880 – Substance Abuse Prevention Services - IOM Populations 885 – Substance Abuse Prevention for Children of Substance Abuser's in RFW Therapeutic CC (IOM Selective Population)

Other Services

Transition and Aftercare for Probationers & Parolees (TAPP)

Definition of Service: TAPP services are designed to provide case management services to eligible discharged inmates linking them to needed treatment, rehabilitation, and/or habilitation programs as well as any other necessary resources provided by existing agencies and programs in or near their local home communities.

Target Population:	Any inmate who being released from a state prison in Georgia with mental illness, co-occurring substance abuse and mental illness, mental retardation/developmental disabilities, or co-occurring mental illness and mental retardation/developmental disabilities.
	The primary purpose of TAPP services is to facilitate successful community reintegration and decrease recidivism, re-incarceration and the use of more intensive hospital services.
Subunit & Modality	Subunit: 355 – Transition and Aftercare for Probationers & Parolees (TAPP) Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

Treatment Court Services

Definition of Service: Treatment Courts are specialized judicial forums designed to facilitate treatment for first-time, non-violent offenders with addictive diseases and/or mental illness. Treatment Courts combine intense judicial supervision, comprehensive substance abuse and/or mental health treatment, random and frequent drug testing, incentives and sanctions, clinical case management and ancillary services. A variety of different services are available through treatment courts:

- **Treatment Courts – Screening, Outreach & Crisis Services**
- **Treatment Courts – Outpatient Services**
- **Treatment Courts – Day & Employment Services**
- **Treatment Courts – Residential Services**

Please refer to the service definitions following for details.

Additional Service Information:

Treatment Courts: Screening, Crisis & Outreach Services (Mental Health & Addictive Diseases)

Definition of Service: The intent of these services is to assess the needs of individuals served, development service plan, refer to appropriate services, and address crisis situations as needed. These services may include: initial screening, diagnostic evaluation, outreach referral and/or crisis intervention.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
MHMRIS: **Subunit & Modality**	Subunit — Modality 915 – Treatment Court – MH — 08 – Outpatient Screening, Crisis & Outreach Services 975 – Treatment Court – AD — 08 – Outpatient Screening, Crisis & Outreach Services
UAS: **Budget and Expense Categories**	115 – Adult Mental Health 715 – Adult Addictive Diseases
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. Providers who deliver screening, crisis and outreach services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Screening, crisis and outreach services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report screening, crisis and outreach expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Outpatient Services (Mental Health & Addictive Diseases)

Definition of Service: These services shall be provided as needed to individuals receiving services through treatment courts and may include: individual, group and family counseling, ambulatory detoxification, community support services, physician and nursing assessment to address the issues that led to involvement in the criminal justice system.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
MHMRIS: Subunit & Modality	Subunit / Modality 916 – Treatment Court – MH Outpatient Services / 08 – Outpatient 976 – Treatment Court – AD Outpatient Services / 08 – Outpatient
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases
Medicaid: For possible related service(s) refer to Medicaid Procedure Code(s):	NONE

Additional Service Information:

1. Providers who deliver outpatient services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Outpatient services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report outpatient expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Day & Employment Services (Mental Health & Addictive Diseases)

Definition of Service: These services are intended for individuals with more severe issues and may include the following services: substance abuse day treatment, peer support, psychosocial rehabilitation services and community-based employment services.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
MHMRIS: Subunit & Modality	Subunit — Modality 917 – Treatment Court – MH Day & Employment Services — 08 – Outpatient 977 – Treatment Court – AD Day & Employment Services — 08 – Outpatient
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases
Medicaid: For possible related service(s) refer to Medicaid Procedure Code(s):	NONE

Additional Service Information:

1. Providers who deliver day and employment services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Day and employment services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report day and employment expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Treatment Courts: Residential Services (Mental Health & Addictive Diseases)

Definition of Service: These services shall be provided to individuals served by treatment courts and may include a wide variety of residential treatment options based on the needs of the individual served.

Target Population:	Adults with mental health and/or substance abuse issues who are directed to services through treatment courts.
Expected Benefit:	Reduction of symptoms and improvement in quality of life resulting in decreased or no involvement with the criminal justice system.
MHMRIS: Subunit & Modality	Subunit / Modality 918 – Treatment Court – MH Residential Services / 04 – Residential 978 – Treatment Court – AD Residential Services / 04 – Residential
UAS: Budget and Expense Categories	115 – Adult Mental Health 715 – Adult Addictive Diseases
Medicaid: For possible related service(s) refer to Medicaid Procedure Code(s):	NONE

Additional Service Information:

1. Providers who deliver residential services under Treatment Court contracts should report expenses for those services using the appropriate UAS budget codes listed above, not the 100 or 700 budget codes.
2. Residential services provided under Treatment Court contracts should be reported to MHMRIS using only the subunits listed above and no other subunits.
3. A provider may report residential expenses and services using budget codes and subunits other than those listed above only for services that are not provided under Treatment Court contracts.

Antipsychotic Drugs - Old Generation Agents

Definition of Service: Medications prescribed by a physician to reduce or eliminate symptoms of psychosis such as hallucinations, delusions and confused thinking. This class of medication often produces numerous unpleasant or even debilitating side effects.

Target Population:	Any individual exhibiting symptoms of psychotic illness.
Expected Benefit:	Reduction in symptoms of psychosis.
MHMRIS: **Subunit & Modality**	Subunit: 601 – Antipsychotic Drugs- Old Generation Agents Modality: 08 - Outpatient
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. Use of antipsychotic drugs is a treatment regimen included as part of a plan of treatment and service for individuals exhibiting symptoms of psychotic illness.
2. Consumers on antipsychotic drugs should be enrolled in MHMRIS for the purpose of reporting drug usage and utilization of different drugs. Consumers may be enrolled in more than one type of drug as prescribed by a physician.
3. For the purpose of reporting to MHMRIS, the use of any old generation agent would be included in this service. This category of drugs would include Chlorpromazine, Fluphenazine, Haloperidol, Loxapine, Mesoridazine, Molindone, Perphenazine, Pimozide, Trifluoparazine, Thioridazine, Thiothixene, and other old generation agents as appropriate.

Antipsychotic Drugs - New Generation Agents

Definition of Service: Medications prescribed by a physician to reduce or eliminate symptoms of psychosis such as hallucinations, delusions and confused thinking. New generation agents often produce superior outcomes by treating a broader range of both positive and negative symptoms of illness with fewer uncomfortable side effects.

Target Population:	Any individual exhibiting symptoms of psychotic illness.
Expected Benefit:	Reduction in symptoms of psychosis with fewer uncomfortable and/or debilitating side effects.
MHMRIS: **Subunit & Modality**	Subunit — Modality Antipsychotic Drugs – New Generation Agents 602 – Clozapine — 08 – Outpatient 603 – Olanzapine — 08 – Outpatient 604 – Quetiapine — 08 – Outpatient 605 – Risperidone — 08 – Outpatient 606 – Ziprasidone — 08 – Outpatient 607 – Aripiprazole — 08 – Outpatient
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. Use of antipsychotic drugs is a treatment regimen included as part of a plan of treatment and service for individuals exhibiting symptoms of psychotic illness.
2. Consumers on antipsychotic drugs should be enrolled in MHMRIS for the purpose of reporting drug usage and utilization of different drugs. Consumers may be enrolled in more than one type of drug as prescribed by a physician.

Ready for Work and Other TANF Programs

Definition of Service: These services are women's gender specific services designed to remove the barriers of addiction, limited mental health and developmental disabilities to employment. These programs are designed for those who meet the TANF needy family definition in order to promote employment, parenting and other life skills. Limited slots are available for Non-TANF individual's who meet the most in need criteria or core customer definition and would benefit from gender specific services.

The following services are provided:

- **TANF and Non-TANF Ready For Work**
- **TANF Mental Health**
- **TANF Development Disabilities Employment**
- **Safe Port**

Some services require the consumer to meet the DFCS definition for "Needy Family". To meet this definition the individual must meet one of three non- financial criteria and one financial requirement:

a. Non-Financial Rules:

1. Current TANF Recipients – Individuals with active TANF cash assistance cases
2. Former TANF Recipients – Individuals whose TANF assistance was terminated within the previous twelve months due to employment
3. Families at Risk – Individuals with active DFCS child protective cases

b. Financial Rules:

1. Income – The limit for the RFW program is set at 235% of the Federal Poverty Level for individuals who are not eligible for TANF cash assistance.

Refer to the service definitions following.

TANF Recipients

Definition of Service: The purpose of this code is to identify women who are TANF recipients (actually receive TANF benefits) receiving Ready for Work Program Services, Safe Port Pilot services, TANF MH outpatient services or TANF DD services.

Because DFCS has adopted a needy family definition for TANF for the purposes of participation in the Ready for Work Program, not all women who are in TANF funded slots will be TANF recipients. We must track TANF recipients in addition to the number of women in TANF funded slots in the Ready for Work Program, Safe Port Pilot services, or TANF funded mental health outpatient services.

Target Population:	Any woman who is a TANF recipient.
Expected Benefit:	Not Applicable
MHMRIS:	Subunit / Modality 811 – TANF Recipients / 04 – Residential 812 – TANF Recipients / 08 – Outpatient
UAS: **Budget and Expense Categories**	NONE
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. If a consumer is enrolled in this service they must also be enrolled in one of the other TANF services.

TANF Ready for Work – Outpatient

Definition of Service: Women's gender-specific substance abuse day supports services beginning with ASAM level 2.5. This includes but is not limited to substance abuse treatment, aftercare, outreach, parenting, support groups, skills building that will support transitioning into work.

Target Population:	Adult women with substance related problems that meet the TANF definition of needy family. See needy family definition for substance abuse.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: **Subunit & Modality**	Subunit / Modality 801 – TANF RFW Outpatient / 08 – Outpatient
UAS: **Budget and Expense Categories**	Substance Abuse 621 – Ready for Work Outpatient – TANF Grant
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. These service slots are funded with TANF federal funds.

Non-TANF Ready for Work – Outpatient

Definition of Service: Women's gender-specific substance abuse day supports services beginning with ASAM level 2.5. This includes but is not limited to substance abuse treatment, aftercare, outreach, parenting, support groups, skills building that will support transitioning into work.

Target Population:	Adult women with substance related problems that **do not** meet the TANF definition of needy family but does meet the core customer definition.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: **Subunit & Modality**	Subunit: 802 – TANF RFW Outpatient Modality: 08 – Outpatient
UAS: **Categories**	Addictive Diseases 620 – Ready for Work Outpatient – SAPT BG
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	

Additional Service Information:

1. These service slots are funded with SAPTBG federal funds.
2. A consumer is determined Non-TANF if:
    a. A woman pregnant for the first time
    b. A woman who has lost parental custody of her children, i.e. is not working on reunification
    c. A woman who is not associated with DFCS (TANF or CPS), meets most-in-need criteria and would benefit from gender specific treatment.

TANF Ready for Work - Residential

Definition of Service: Women's gender-specific substance abuse residential treatment services beginning with ASAM level 3.5. This includes but is not limited to substance abuse treatment, aftercare, outreach, parenting, support groups, skills building that will support transitioning into work.

Consumers should be enrolled in TANF Ready for Work – Residential if the funded slots were with the original TANF funds for this program. If a consumer is in a slot that was an added TANF slot then the see the service definition for TANF AP Ready for Work – Residential.

Target Population:	Adult women with substance related problems that meet the TANF definition of needy family. See needy family definition for substance abuse.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: Subunit & Modality	Subunit: 803 – TANF RFW Residential Modality: 04 – Residential
Categories	Addictive Diseases 625 – Ready for Work Residential – TANF Grant
For possible related service(s) refer to Medicaid Procedure Code(s):	

Additional Service Information:

1. THESE SERVICE SLOTS ARE FUNDED WITH TANF FUNDS.

TANF (AP) Ready for Work – Residential

Definition of Service: Women's gender-specific substance abuse residential treatment services beginning with ASAM level 3.5. This includes but is not limited to substance abuse treatment, aftercare, outreach, parenting, support groups, skills building that will support transitioning into work.

Consumers are enrolled in this service if they are NOT in a slot that was funded with original TANF funds for his program. These are additional slots that were allocated after the original slots for this program was funded. For consumers in original TANF funded slots refer to the service definition for TANF Ready for Work – Residential.

Target Population:	Adult women with substance related problems that meet the TANF definition of needy family.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: **Subunit & Modality**	Subunit: 807 – TANF AP RFW Residential Services Modality: 04 – Residential
UAS: **Budget and Expense Categories**	Addictive Diseases 623 – AP RFW TANF Residential
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. THIS SERVICE IS FUNDED WITH TANF AP FEDERAL FUNDS.

Non-TANF Ready for Work - Residential

Definition of Service: Women's gender-specific substance abuse residential treatment services beginning with ASAM level 3.5. This includes but is not limited to substance abuse treatment, aftercare, outreach, parenting, support groups, skills building that will support transitioning into work.

Target Population:	Adult women with substance related problems that **do not** meet the TANF definition of needy family but does meet the core customer definition.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: **Subunit & Modality**	Subunit — Modality 804 – Non-TANF RFW Residential — 04 – Residential
UAS: **Budget and Expense Categories**	Addictive Diseases 624 – Ready for Work Residential – SAPT BG
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. These service slots are funded with SAPTBG federal funds.
2. A consumer is determined Non-TANF if:
   a. A woman pregnant for the first time
   b. A woman who has lost parental custody of her children, i.e. is not working on reunification
   c. A woman who is not associated with DFCS (TANF or CPS), meets most-in-need criteria and would benefit from gender specific treatment.

TANF Mental Health Outpatient Services

Definition of Service: This service is mental health counseling designed to address the specific mental health needs of those who meet the TANF definition of needy family and for whom a mental health issue is determined a real barrier to successful employment. This includes their children or significant others who have been identified as having a mental health issue. TANF MH services include but are not limited to mental health assessment, case management and coordination, outreach services, and skills building that will support transitioning into work. Life skills, anger management, relationship issues are typical TANF MH issues. V-codes and some AXIS 1 diagnosis for non-SPMI are included but is not limited to dysthymia, personality disorders, adjustment disorders, generalized anxiety, single episode depression (mild) social phobia.

Target Population:	Adult women with mental health problems that meet the TANF definition of needy family but **do not** meet the most-in-need criteria.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: **Subunit & Modality**	Subunit: 806 – AP TANF Mental Health Outpatient Services Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	Mental Health 020 – TANF MH Outpatient
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. These service slots are funded with TANF federal funds.

TANF Substance Abuse Safe Port

Definition of Service: TANF Safe Port project now known as the Millennium Center (MC) is a therapeutic community that serves women and families who are in need of services stemming from addiction and trauma. This includes but is not limited to substance abuse treatment, aftercare, outreach, parenting, support groups, skills building that will support transitioning into work.

Target Population:	Adult women with substance related problems that meet the TANF definition of needy family in the West Central region.
Expected Benefit:	Improved life skill functioning and employment.
MHMRIS: **Subunit & Modality**	Subunit: 809 –TANF SA Safe port Modality: 04 – Residential
UAS: **Budget and Expense Categories**	Addictive Diseases 627 – TANF SA Safe Port
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. This sub-unit is for providers in West Central only for a pilot of the Safe Port SA model, which will include a comprehensive array of services for long-term TANF recipients and others who meet the TANF definition of needy family. Ancillary services are also provided to family members and their children, however, the primary consumer is the adult woman.
2. This service is funded with TANF federal funds.

TANF DD Employment Services

Definition of Service: Services include assessment, vocational training, vocational counseling, job development, job placement, linkages to generic and natural supports, and direct on the job support.

Target Population:	Adult women with developmental disability (DD) issues limited to history of special education, learning disabilities, and behavior management that meet the TANF definition of needy family but do not meet the most-in-need criteria for (DD) services.
Expected Benefit:	Appropriate employment placement.
MHMRIS: **Subunit & Modality**	Subunit: 810 – TANF MR Modality: 08 – Outpatient
UAS: **Budget and Expense Categories**	Developmental Disabilities 520 – TANF Mental Retardation Funds
Medicaid: **For possible related service(s) refer to Medicaid Procedure Code(s):**	NONE

Additional Service Information:

1. This service is funded with TANF federal funds.
2. Ancillary services are also provided to family members and their children, however, the primary consumer is the adult woman.